



**STATE OF WASHINGTON  
LEGISLATIVE BUDGET COMMITTEE  
506 EAST 16TH  
OLYMPIA  
98504**

# **RESIDENTIAL SERVICES FOR CLIENTS WITH DEVELOPMENTAL DISABILITIES PHASE I**

**Report No. 91-2**

**A Report to the  
WASHINGTON STATE LEGISLATURE  
January 17, 1991**

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Under provisions of the 1990 state supplemental budget, the LBC was directed to evaluate residential programs for persons with developmental disabilities and the population reduction or "downsizing" of state institutions. The evaluation has been divided into phases. This report concludes phase I and describes the downsizing policy, process, and results through November 1990. The report also outlines plans for completing the evaluation.

## PHASE I

By late November 1990, through the downsizing program, about 140 people had been moved from state institutions to community residential programs. About 45 of those persons were moved to the new State Operated Living Arrangements (SOLAs), where care is provided by state employees. With a few exceptions the others have been placed in similar intensive tenant support (ITS) programs operated by private providers.

In accordance with legislative mandates, the downsizing program emphasized the opportunity for the parent or guardian to choose: (1) whether the client should remain in the institution or move to the community, and (2) the type of community placement; i.e., private- or state-operated. We surveyed parents and guardians of persons who have moved. We found that they are:

- Very satisfied with the decision-making process, and
- Very satisfied with the actual community placement.

The downsizing policy was intended in part to help the institutions meet federal standards, through an enriched staffing ratio for the clients who remain in the "downsized" state institutions. The strategy was unsuccessful. In 1990 three of the six state institutions were found out of compliance with federal standards. Federal funding is currently endangered at Fircrest, Rainier, and Interlake.

In November 1990 the Division of Social and Health Services (DSHS) completed a Comprehensive Plan for the Developmental Disabilities Institutions which presents three alternative models of service delivery and funding. Legislative input on future plans for developmental disabilities (DD) programs is being sought in the 1991 session.

## PHASE II PLANNING

We recommend an immediate Phase II-A study effort (January-March 1991) to provide the legislature with information useful for decisions that may be required in 1991. This part of the evaluation would consist of a comprehensive cost comparison of major types of residential care.

Phase II-B of the study (starting by July 1991) should be sufficiently flexible to accommodate any newly-emerging issues. Subject to availability of resources, we recommend the following topics for study:

1. The experiences of selected other states, with particular regard to those who have significantly reduced or eliminated institutional populations through transfers to community placements, and to any other innovative programs with potential application in Washington State.
2. Future DD program directions, which would include a brief update on the continuing problems of federal institutional standards and related surveys and federal funding. Options would be explored for further institutional reductions or closures to accommodate various alternative population levels, and possible uses for closed facilities.
3. Program criteria and outcomes, which would include attempting to identify program performance criteria useful to the legislature, assessment of the quality of life being experienced by individuals moved to the community, and the achievement of desired behavior modifications and independent living skills of those who have moved.

The study completion date should be changed from December 1, 1991, to ~~December~~ September 1, 1992, in view of the limited time between anticipated funding (July 1, 1991) and the current completion date (December 1, 1991). (Recommendation amended by final committee action.)

## AGENCY RESPONSE

DSHS has expressed satisfaction with the report contents and concurrence with the recommendations.

## ACKNOWLEDGEMENTS

Frank Hensley and Matt Temmel of the LBC staff prepared this report. Carol Kruse and Kristen West also participated in the conduct of this study.

**We gratefully acknowledge the cooperation of the management and field staff of the DSHS Division of Developmental Disabilities, the research staff of the Developmental Disabilities Planning Council, service providers, parents, and others who contributed to this report.**

**Cheryle A. Broom  
Legislative Auditor**

**On January 17, 1991, this report was approved as amended by the Legislative Budget Committee and its distribution authorized.**

**Representative Helen Sommers  
Chair**

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## I. SCOPE AND OBJECTIVES

### Scope

This project reviews and documents the history and efforts of the DSHS Division of Developmental Disabilities relevant to moving people with developmental disabilities from state institutions to community placements (popularly known as "downsizing"). The project scope includes both publicly-operated and private-contractor-operated community programs. The project also seeks to identify key issues for Phase II of this study.

### Objectives

1. To summarize the events leading to downsizing.
2. To describe the process of moving clients from institutions to residential programs in the community, and the results achieved to date, including:
  - a. Compliance with legislative intent.
  - b. Client characteristics.
  - c. Parent/guardian satisfaction or dissatisfaction with the process.
3. To identify relevant related issues for inclusion in Phase II of this evaluation.

### Legislative Proviso

Section 103 of Substitute Senate Bill 6407 (1990) added the following proviso to the Legislative Budget Committee's appropriation:

"The appropriation in this section is subject to the following conditions and limitations: \$25,000 is provided solely to plan and contract for an independent evaluation of state-operated and community-operated residential services for developmentally disabled clients. The evaluation shall document the efforts of the department of social and health services and compare the cost and quality of state-operated and community-operated services. The evaluation shall make recommendations to the legislature on expansion of community programs and the role of residential habilitation centers in the range of programs available to persons with developmental disabilities. The impact of auditing procedures, funding sources, and limitations on capital and operating budgets shall be included. The evaluation shall be submitted to the legislature by December 1, 1991."

## **II. BACKGROUND**

### **A. Introduction**

This study was conducted in response to a mandate in the state budget for an independent evaluation by the Legislative Budget Committee.

The evaluation is being conducted in phases. This report concludes Phase I. In Chapter III we summarize the policy, process and results to date of the current effort to reduce the number of residents of state institutions for the developmentally disabled by transferring residents to community residential placements. In Chapter IV we summarize current plans for additional phases of the study.

### **B. Methods**

The study methodology for Phase I included:

- A review of pertinent national literature in the field.
- Visits to five of the six state institutions and several community residential programs.
- Numerous interviews with representatives of DSHS management, interested parents, contractual providers, a state employees' union, standing committee staff and members, and others.
- Attendance at the annual Developmental Disabilities Residential Conference.
- A survey of parents and guardians of persons moved from state institutions to community settings as part of the downsizing program.
- Analysis of client data contained in the information system of the DSHS Division of Developmental Disabilities.

### **C. What is Downsizing?**

A summary developed by DSHS for the House Appropriations Committee answered the question as follows:

- Moving away from care in large facilities to smaller supported-living alternatives.
- Reducing the populations of the state institutions by increased use of these alternatives.

- A philosophy that community living is more appropriate than large institutional care.
- A strategy developed by the Governor's task force in response to the increased federal demands on residential habilitation centers (RHCs) and the resulting increased costs.
- This strategy means reducing the number of clients in RHCs (institutions) but keeping the same number of staff. This increases the client-to-staff ratio.

This study deals only with the movement of persons with developmental disabilities from the state institutions, but not with the concurrent efforts to move people from privately-operated intermediate care facilities and nursing homes. Officially, the effort to move persons from the state institutions to community placements is called "Expanded Family Choices." In this report we use the more common term "downsizing."

#### **D. The Downsizing Process**

Downsizing includes various procedural safeguards to guarantee under state law the opportunity for clients, parents, or guardians to choose a residential placement. The process varies by institution and probably has changed over time. In general, however, the process in 1989-90 was as follows:

##### **1. Initial Notice**

Each institution identified residents who might be interested in a community placement and whose parents, guardian, or advocate might agree to a move. Those parents or guardians were informed of the options. The discussions were continued if the parent, guardian, or advocate expressed interest.

##### **2. Personal Futures Planning Conferences**

These conferences were held to identify the client's desires and interests. Participants usually included the client, family, friends, and staff members.

##### **3. Referral to Division of Developmental Disabilities (DDD) Community Services**

If the parent or guardian reaffirmed interest in a community placement, they were referred to a DDD regional office. The staff briefed parents or guardians on the available options, matched the client with a community residential program provider, and developed support services.



**4. Visits to Community Residential Programs**

Many clients, parents, or guardians visited houses or apartments where they might move, including contracted and state-operated programs. In some cases the client moved in for a trial residence before a decision was made.

**5. Letter of Intent**

This document specifies the services to be provided in the community and guarantees that the client may return to the institution if the community placement is unsuccessful.

### III. DOWNSIZING POLICY AND IMPLEMENTATION

This chapter is our review of the downsizing program as of early December 1990. The material is organized as follows: (a) reasons for downsizing; (b) current status in making community placements; (c) client data on persons who have moved; (d) parent satisfaction; (e) miscellaneous issues about community placements; and (f) certification status of the "downsized" state institutions.

#### A. Reasons for Downsizing

Washington's six state institutions for the mentally retarded, known as residential habilitation centers (RHCs), incur operating costs of about \$250 million per biennium. Some 54 percent of this amount, or \$136 million, is paid by the federal government as its share of Title XIX (Medicaid) funding.

As a condition of receiving federal funding, each RHC must be certified once a year as meeting the regulatory standards for the Intermediate Care Facilities/Mentally Retarded (ICF/MR) program. Federal and state "surveyors" (program auditors) review the institutions to determine whether they are in compliance with the "conditions of participation." Federal funding may be reduced or terminated if an institution is out of compliance.

In 1984 the federal government began tightening the ICF/MR regulatory standards, and the RHCs faced increasing difficulty in retaining their Medicaid certification and funding. In 1988, at the direction of the Governor, a DSHS task force conducted a comprehensive review of Washington's continued participation in the ICF/MR program.

The task force recommended movement to community placements of about 300 RHC residents, out of a total population of some 1800. Federal funding is available through the Medicaid community-based waiver program. The community placements are subject to state quality standards, in lieu of the federal ICF/MR standards.

As the RHC populations declined, according to the task force, the number of institution staff was to be kept the same, thereby enriching the staff-to-client ratios and permitting better service. This change, it was believed, would help the "downsized" institutions retain ICF/MR certification.

The downsizing policy decision was also based on research evidence that community living is preferable to institutional care for many persons with developmental disabilities. Studies in other states have shown that persons transferred from institutions to community residential programs make significant advances in adaptive behavior and independent living skills.

In summary, the current policy of moving RHC residents to community placements is the state's response to problems in meeting standards for Medicaid certification of the RHCs. In addition, downsizing is based on the view that community residential programs can achieve better client outcomes compared to an institutional setting.

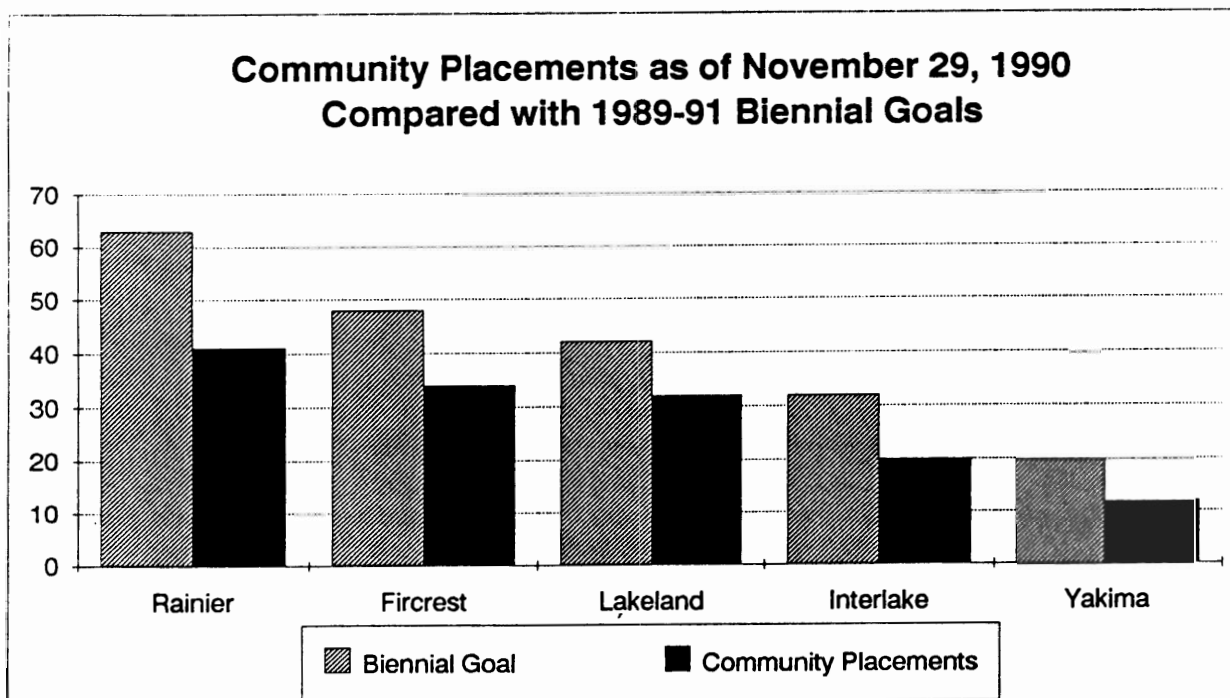
## **B. Number of Community Placements**

In 1989 five of the six RHCs failed their Medicaid certification surveys. In response DSHS decided to move about 205 clients to community placements during the 1989-91 biennium. By November 1990, about 140 persons had moved. Exhibit 1 (below) shows the community placements from each institution in relation to the 1989-91 biennial goals.

For Fircrest the exhibit shows a goal of 48 community placements by the end of the biennium (June 1991). However, further moves will have to be made to comply with the federal "plan of reduction" adopted in 1989. Under that plan, the Fircrest population must be reduced by 118 by August 1992.

The downsizing goals for the other institutions were originally set by DSHS for various times in 1990, in response to adverse ICF/MR survey results the previous year. Each institution failed to reach the goal by the original date. DSHS then revised the target dates to the end of the biennium.

**Exhibit 1**



Some reasons for the delays in making community placements are:

- Problems in finding suitable rental housing, especially in King County.
- Difficulties in locating medical providers who accept Medicaid coupons.
- Coordination problems with the counties in developing day programs.
- The first six months of the biennium were devoted to planning, and the actual moves from the RHCs to community placements did not actually begin until late December 1989.

### C. Client Data

We collected data on 109 clients who had moved from RHCs to community placements between late 1989 and mid-September 1990. The source was the information system maintained by the DSHS Division of Developmental Disabilities. The purpose was to identify possible differences in the severity of disabilities of the clients placed in various living arrangements:

- **State-operated living arrangements (SOLA)** developed in connection with RHC downsizing. The attendant care staff are state employees with RHC experience. The level of care, such as 24-hour staffing, is the same as in private intensive tenant support programs.
- **Intensive tenant support (ITS)** programs operated by contractors. These programs are subject to the same state standards as SOLAs.
- **Group homes (GH) and adult family homes (AFH)** operated by contractors. These programs have a lower staffing level.

Exhibit 2 (next page) shows the client data by type of community placement. The data suggest that the clients are similar, especially the SOLA and ITS clients. Note that the distribution of level of mental retardation is almost the same in these placements. Program authorities indicate that the SOLA and ITS clients are similar, although some advocates of SOLAs maintain that clients in those placements have more difficult behavior problems.

The issue cannot be further resolved at this time because the information system contains no data on client behaviors or living skills. We may address this question later in the evaluation.

### Client Data by Type of Community Placement -- through mid-September 1990

Includes 109 moves to community placements. Excludes moves out of state and to another state institution.

	<u>Moved to SOLA*</u> N = 30		<u>Moved to ITS*</u> N = 67		<u>Moved to GH or AFH*</u> N = 12		<u>TOTAL</u> N = 109
Age Range	14 to 50		17 to 68		18 to 70		14 to 70
Median Age	31		36		33		34
<u>Mental Retardation Level:</u>							
Mild	4	13% of 30	7	10% of 67	5	42% of 12	16 15% of 109
Moderate	7	23%	17	25%	0	0%	24 22%
Severe	6	20%	12	18%	3	25%	21 19%
Profound	12	40%	30	45%	4	33%	46 42%
Unknown	1	3%	1	1%	0	0%	2 2%
<u>Other Conditions:</u>							
Autism	1	3% of 30	8	12% of 67	1	8% of 12	10 9% of 109
Cerebral Palsy	8	27%	12	18%	1	8%	21 19%
Deaf	2	7%	2	3%	0	0%	4 4%
Blind	6	20%	8	12%	1	8%	15 14%
Epilepsy	12	40%	24	36%	4	33%	40 37%
Dual Diagnosis	0	0%	1	1%	0	0%	1 1%

**\* Key**

SOLA = State Operated Living Arrangement

ITS = Intensive Tenant Support (contracted)

GH = Group Home (contracted)

AFH = Adult Family Home (contracted)

LBC: MT 10/31/90. Source: DDD Info. System

#### **D. Parent Satisfaction**

"Parent choice" is an integral part of the downsizing effort. Under a long-standing state policy, as reinforced by provisions in the current state budget, no client may be moved from a state institution to a community placement without the consent of the parent or guardian. Thus, parent satisfaction is a crucial aspect of the success of the downsizing policy.

We conducted a mail survey of the parents or guardians of all RHC residents who moved to the community between late 1989 and August 1, 1990. The questionnaire was designed to test: (1) satisfaction with the process used by DSHS to select and move clients, and (2) satisfaction with the community placement. The survey had a return rate of 82 percent.

We found that a large majority of parents and the other respondents are very satisfied with both the downsizing process and the community placement. Appendix 2 contains a detailed analysis.

#### **E. Miscellaneous Issues about Community Placements**

We examined DSHS' performance in connection with various provisos about downsizing contained in the current state budget. The provisos were intended to: (1) ensure parent choice, and (2) restrict development of SOLAs at the expense of privately contracted placements. We found that:

1. Parents, guardians, or relatives of institution residents were repeatedly notified by DSHS staff of the opportunity to make a choice, and most were actively involved in the decision about whether and where to move their relative. Our parent survey (Appendix 2) shows very high satisfaction with the downsizing decision process.
2. The supplemental budget required DSHS to allocate up to \$151,000 to certain counties to prepare directories of community services for people with developmental disabilities, presumably to help parents and others make informed choices about community placements. We found that the directories have been compiled and will be published by DSHS in late 1990 or early 1991. Although directories have played no role in residential movement decisions to date, when published they will be widely distributed to all interested persons.
3. By November 1990 the SOLAs had 45 residents (half in King County), or one-third of the community placements of former RHC residents. We found no evidence that SOLAs have negatively impacted private contracted residential programs. New private providers have entered the field, and others have expanded to meet the demand for community placements.

4. Our parent survey sheds some light on the reasons for choosing a SOLA. Parents of some SOLA residents chose a SOLA because they believe that a state-operated program has more secure funding and offers more experienced care than an intensive tenant support program run by a state contractor. Parents of other SOLA residents chose a SOLA because of preferences about location, friends to share the house, or other factors unconnected with whether the living arrangement is state-operated or privately-operated.

#### F. RHC Certifications

The policy of reducing institutional populations through community placements was intended in part to assist the state institutions in retaining their ICF/MR certification and Medicaid funding, through improved staffing ratios and quality control efforts for the remaining facility residents.

Exhibit 3 (next page) shows the 1989 and 1990 certification status of the RHCs; i.e., passage or failure of the "surveys" that determine compliance with ICF/MR regulations. As shown in the exhibit, three of the six institutions failed their 1990 surveys. These results could mean:

- Termination of federal funding for Rainier and Interlake in January 1991. However, a re-survey is under way at Rainier to determine if parts of the facility are in compliance and may continue to receive federal funds. Options at Interlake are under study by DSHS.
- Termination of federal funding for Fircrest in February 1991, since the institution was found out of compliance with the plan of correction agreed to with the federal government. Appeals may delay and modify funding losses.

These developments call into question some aspects of the current downsizing policy:

1. It was hoped that improved staffing ratios (two staff per resident) would result in continued certification. Given the recurring problems with certification, it is questionable whether increased staffing ratios will produce the desired results.
2. The downsizing policy was intended to move out RHC residents while holding constant the number of RHC staff. However, in late 1990 DSHS decided to add 90 temporary staff positions at Rainier. The agency budget request for 1991-93 is expected to include large staff increases at the institutions. These developments change a basic feature of the downsizing policy and could lead to major increases in institutional costs.

Exhibit 3

Residential Habilitation Centers  
"Surveys" (Audits) for Medicaid Certification

<u>RHC</u>	<u>1989</u>	<u>1990</u>
Fircrest	Fail (1)	Fail (1)
Rainier	Fail (2)	Fail (3)
Lakeland	Fail (2)	Pass
Interlake	Fail (2)	Fail (3)
Yakima	Fail (2)	Pass
F. H. Morgan	Pass	Pass

Notes

- (1) Fircrest failed in 1989. By agreement with the federal government, the institution adopted plans to correct conditions and reduce the population by 118 residents by August 1992. In early December 1990 Fircrest again failed a survey and has 60 days to come into compliance.
- (2) Rainier, Lakeland, Interlake, and Yakima failed their 1989 surveys. Effects: (a) Medicaid funding was denied for new admissions, but was continued for one year for current residents, and (b) the state decided to reduce the RHC populations, as a way of enriching the staffing ratio and helping to pass future surveys.
- (3) Rainier and Interlake failed in 1990 and appealed the decisions. Effects: (a) Medicaid funding continues for 120 days, until January 1991; (b) Rainier is being re-surveyed, to determine if parts of that institution (PATs, or program area teams) have come into compliance and thus may continue to receive Medicaid funds; and (c) DSHS will move some Interlake residents to Lakeland, and is studying options to restructure Interlake in order to retain federal funding.

LBC:MT 12/4/90



## IV. SUBSEQUENT STUDY PHASES

### A. Introduction

The budget proviso which mandated this evaluation is general as to purpose, scope and objectives of the study, but calls specifically for:

- Recommendations on expansion of community programs
- Recommendations on the role of the residential habilitation centers (institutions).

Both of these subjects will be addressed in subsequent phases of the evaluation.

Two general constraints make it difficult to propose firm evaluation plans at this time:

- The Changing Environment -- Three of the six state DD institutions have recently failed their compliance audits and are in danger of losing federal funding. In response, DSHS has developed a new comprehensive plan for the institutions which contains three alternative models for residential care and funding. Legislative input and action is anticipated in the 1991 session.
- Study Schedule and Budget -- Study funding for the 1991-93 biennium will not be available until July 1, 1991, leaving only five months before the study completion date. This is inadequate to fully respond to legislative concerns. We recommend changing the due date to December 1, 1992.

### Recommendation 1

That the LBC seek amendatory legislation or otherwise change the completion date for the evaluation from December 1, 1991, to ~~December~~ September 1, 1992. (Recommendation amended by final committee action.)

### B. Phase II-A Study Issue: Residential Programs Cost Comparisons

Discussion -- We asked DSHS to prepare "best estimates" of daily costs per resident for selected residential programs. Exhibit 4 contains these figures. There is agreement that a comparison of these figures is misleading for the following reasons:

- Capital costs are included in some figures but not in others.

## Exhibit 4

# WEIGHTED AVERAGE DAILY SUPPORT COSTS FOR "PROJECT OPTIONS" CLIENTS

A) RESIDENTIAL HABILITATION CENTERS (1)		\$225
B) STATE OPERATED LIVING ALTERNATIVES		\$305
RESIDENTIAL (2)	\$260	
MEDICAL(4)	5	
EMPLOYMENT/DAY(5)	27	
SSI AVERAGE(6)	13	
C) GROUP HOME		\$148
RESIDENTIAL(3)	\$111	
MEDICAL(4)	5	
OTHER SUPPORT(3)	14	
EMPLOYMENT/DAY(5)	18	
D) INTENSIVE TENANT SUPPORT		\$218
RESIDENTIAL(3)	\$134	
MEDICAL(4)	5	
OTHER SUPPORT(3)	44	
EMPLOYMENT/DAY(5)	22	
SSI AVERAGE(6)	13	

## NOTES:

- (1) Weighted average claiming rate.
- (2) Estimated average expenditures per resident day at capacity.
- (3) Average daily expenditure through Septmeber 1990.
- (4) Average medical expenditures for CAP waiver clients from HCFA 372 inflated for FY 91.
- (5) Average expenditure.
- (6) Average daily SSI benefit.

- Federal payments made directly to persons with developmental disabilities vary with individual programs.
- The cost of SOLAs to date has included start-up costs and is therefore probably overstated in comparison to the ITS operating costs.
- Medical, dental, therapy, day programs and vocational programs are included in some costs but not in others.
- Institutional costs per person per day have little flexibility, and a reduced population at a given institution does not reduce costs on an equivalent basis. (Only if an institution is closed are the cost savings of a reduced population fully realized.)

This topic is important in view of the legislature's need for information in connection with the budget and related DD program decisions in the 1991 session.

Study Objective -- Identify all cost elements related to each selected residential program and applicable funding sources. Prepare comparable federal and state costs applicable to each program.

## Recommendation 2

That the LBC proceed immediately with a Phase II-A study to be completed by March 31, 1991, to produce a comprehensive comparison of costs in contracted intensive tenant support programs, state-operated living arrangements, group homes, and state institutions.

## C. Phase II-B Study Issues

The following items are recommended for inclusion in Phase II-B of the evaluation. Revision of these plans may be appropriate in view of any emerging issues. The items are listed in order of suggested priority. The number of items actually undertaken will be dependent upon funding and available staff resources.

### 1. The Experience Of Other States

Discussion -- Several other states claim to have virtually eliminated their state institutions for persons with developmental disabilities, transferring the client base to community placements. Review of the experiences of these states appears a cost-effective way to gain valuable information about the process and results of this national trend.

Other states have also developed several options and alternatives within their DD programs, such as a voucher system which allows parents to choose the services most needed for a family member to remain at home.

Some aspects of the programs in other states to be reviewed would be cost impacts, federal funding utilized, the type of community placements most successfully utilized, major problems encountered, major benefits gained, and degree of acceptance by clients, parents and guardians.

Study Objectives -- To identify the methods, successes, failures, problems and costs of institution-to-community movements of DD clients in selected states. To identify and evaluate the feasibility of successful innovative ideas used elsewhere, for inclusion in the DD program of this state.

## 2. Future Program Directions

### a. Update On Federal/State Relations

Discussion -- This issue would include a summary of the status of the following items as a basis for future decisions:

- Federal standards, surveys and funding of state institutions.
- Federal laws and regulations impacting funding of community residential programs.
- DSHS strategy and success in responding to the above.

Study Objective -- To briefly summarize federal laws and regulations relating to standards and funding, and DSHS strategy and success in responding to them, as a basis for future planning.

### b. The Future Of The Institutions

Discussion -- This study item would review potential closures or conversions to other usage, to accommodate several alternative levels of institutional population. Items to be considered would include:

- Quality and condition of physical plant.
- Needs of the patient population served and appropriateness for community placement.
- Availability of alternative placements.
- The location of individual institutions in relation to parents, guardians, and friends.
- Estimated cost impacts.

As part of this topic, the study could also survey alternative DD-related uses for all or portions of any facilities vacated. This item presumes that closure of one or more institutions is an alternative which the legislature wishes to consider.

Study Objective -- To develop recommendations as to the future of state institutions.

### **Recommendation 3**

That, subject to the availability of resources, Phase II-B of the evaluation address: (1) the experience of other states relative to downsizing and innovative DD programs, (2) future DD program directions for both the state institutions and community residential placements, and (3) program criteria and outcomes relevant to community placements, with emphasis upon quality of life, adaptive behavior, and independent living skills.

#### **D. General Policy Framework**

Programs for persons with developmental disabilities are a subject about which we found widely varying opinions and strong feelings. Underlying philosophical values on such matters as the role of government and parental rights affect an individual's views toward these programs. On other questions we found no clear answers among professional authorities in the developmental disabilities field.

Previous sections of this chapter deal with issues we believe are difficult but feasible to assess from a cost-effectiveness or program performance perspective. Below are some of the policy-level questions we encountered which are less amenable to empirical evaluation, but are important within the legislature's overall DD policy framework.

- o What is the extent and nature of the state's responsibility to citizens with developmental disabilities? What is the relative budget priority for DD programs? What is the proper amount of resources to commit to this purpose?*
- o Should all DD clients be served in the community, including the profoundly disabled, the medically fragile, and those disabled persons who may be a security risk to the public?*
- o Should the state attempt to address the widely-perceived inequity between (a) the substantial amount of resources expended on persons with developmental disabilities who receive state-supported residential services of all types, and (b) the more limited resources to support the efforts of families that are caring for members with developmental disabilities in their own homes?*
- o Who should be empowered to make decisions to move patients from institutions to the community? What relative weight should be given to the views of parents and guardians as opposed to those of professional staff?*

c. **The Future Of Community Programs**

Discussion -- This study item would seek to identify and assess alternative policy courses for DD community residential programs. It would assess the progress of SOLA and ITS programs to date, including the latest cost data. The findings of the DDD quality assurance program for community placements would be examined.

Study Objective -- to develop recommendations as to the future of state DD community residential programs.

3. **Program Criteria And Outcomes Evaluations**

a. **Quality Of Life**

Discussion -- Although improved "quality of life" is a key reason set forth by advocates for moving clients to community placements, Phase I revealed few acceptable criteria for measuring the effectiveness of various DD residential programs. Since substantial funding and program changes are involved, it seems appropriate to seek and utilize criteria with which program effectiveness can be ascertained. If necessary, subjective measures can be utilized such as patient/parent/guardian satisfaction levels and DSHS quality assurance team findings on such items as community contacts and the availability of personal choices.

Study Objective -- To identify measures or criteria that the legislature could use to measure various DD residential programs' impact on the quality of life. To measure and compare alternative programs using available criteria.

b. **Behavioral Outcomes And Independent Living Skills**

Discussion -- Some measure of the success or failure of community residential placements can be attributed to improved or deteriorated behavior of those moved, including the development of independent living skills. An evaluation of behavioral and skill level changes would be useful in determining the value of community residential programs.

Several approaches are possible, including: (1) direct measure by a qualified professional comparing pre-move and post-move behavioral patterns, (2) subjective interviews with residents, staff, and parents or guardians, and (3) review of previous studies in other states that have addressed this question. As the most cost-effective approach, we recommend a review of other studies dealing with comparable community placements. The similarity of in-state results could be confirmed with subjective input, such as staff and case manager interviews and review of patient files.

Study Objective -- An assessment of behavioral changes of DD residents moved from institutions to a community setting.

*o Is the current policy which divides responsibilities between state and local government appropriate in terms of local control and involvement, accountability, responsibility, and consistency of services throughout the state?*

## **Appendix 1**

### **SUMMARY OF RECOMMENDATIONS**

#### **RECOMMENDATION 1**

That the LBC seek amendatory legislation or otherwise change the completion date for the evaluation from December 1, 1991, to ~~December~~ September 1, 1992. (Recommendation amended by final committee action.)

Legislation Required:	Pending LBC or other action
Fiscal Impact:	None
Completion:	June, 1991

#### **RECOMMENDATION 2**

That the LBC proceed immediately with a Phase II-A study to be completed by March 31, 1991, to produce a comprehensive comparison of costs in contracted intensive tenant support programs, state-operated living arrangements, group homes, and state institutions.

Legislation Required:	None
Fiscal Impact	Consultant contract anticipated (Estimated total \$9900) in FY 1991
Completion:	March 31, 1991

#### **RECOMMENDATION 3**

That, subject to the availability of resources, Phase II-B of the evaluation address: (1) the experience of other states relative to downsizing and innovative DD programs, (2) future DD program directions for both the state institutions and community residential placements, and (3) program criteria and outcomes relevant to community placements, with emphasis upon quality of life, adaptive behavior, and independent living skills.

Legislation Required:	None
Fiscal Impact:	\$89,051 is anticipated cost and is included in LBC budget request for 1991-93.
Completion	December 1, 1992



## Appendix 2

### PARENT AND GUARDIAN SURVEY

To evaluate parent and guardian satisfaction on various downsizing issues, we conducted a mail survey. Questionnaires were mailed out on September 17, 1990 and returned by October 11. The persons who were surveyed represented the clients in the downsizing process. They included parents, guardians, relatives, or friends of all RHC residents who moved to community placements between December 19, 1989, and August 1, 1990. Survey universe = 62. Responses = 51. Survey return rate = 82 percent.

Excluded from the formal survey were paid advocates and guardians with multiple clients who moved during the same period. Those persons were interviewed and gave answers similar to those obtained in the mail survey.

The survey responses were proportionally distributed in terms of the former RHC and the type of community placement, as shown in the following charts.

#### Breakdown by Former Institution

<u>Former Institution</u>	<u>Questionnaires</u>		<u>Return Rate</u>
	<u>Sent</u>	<u>Returned</u>	
Fircrest	18	15	83%
Rainier	17	12	71%
Lakeland	17	16	94%
Interlake	6	5	83%
Yakima	4	3	75%
	-----	-----	-----
TOTAL	62	51	82%

#### Breakdown by Type of Community Placement

<u>Community Placement</u>	<u>Questionnaires</u>		<u>Return Rate</u>
	<u>Sent</u>	<u>Returned</u>	
Intensive Tenant Support	27	20	74%
Group Home	6	5	83%
Adult Family Home	2	1	50%
Out of State--Idaho	4	3	75%
State Operated (SOLA)	23	22	96%
	-----	-----	-----
TOTAL	62	51	82%

The questionnaire is reproduced on the following pages, with annotations to indicate the responses to each question. The following comments refer to the most important survey findings.

The responses indicate very high satisfaction with (1) the process used to notify parents and involve them in the decision-making process, and (2) the community placement.

The survey was designed in part to determine whether parents and other respondents felt "pressured" by DSHS staff to move their family member out of the institution. (We have received comments to this effect.) As shown in question 5, only 8 respondents out of 51 (16%) gave an affirmative answer. We analyzed the responses of these eight respondents to see if their feeling of being pressured was associated with other negative answers, such as dissatisfaction with the actual community placement. We found that the eight pressured respondents were satisfied with the community placement (questions 26, 27, and 28).

Questions 7 through 14 were designed to ascertain respondent knowledge and opinions on the type of community placement, such as the distinction between a state-operated and privately-operated placement. In response to question 7, 38 out of 51 respondents correctly identified the type of community placement. Another finding is that about one-third of the respondents whose family member moved to a SOLA may not have chosen that placement because the program is staffed by state employees. Other factors, such as location or preferences about friends residing in the SOLA unit, were apparently considered more important by that subgroup.

Questions 15 through 21 dealt with decision criteria and information available to the parents or guardians. Questions 22 through 25 concerned satisfaction with the process. Questions 26 through 28 concerned satisfaction with the placement.

# Legislative Budget Committee - Parent and Guardian Survey

## Tabulation of Results

Name of Person Who Moved: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Your Name: \_\_\_\_\_

1. What is your relationship to the above person? (check all that apply)

- |  |                            |           |
|--|----------------------------|-----------|
| <input type="checkbox"/> a. Parent         | <b>Unduplicated Count:</b> |           |
| <input type="checkbox"/> b. Other Relative | Parent & Guardian          | 21        |
| <input type="checkbox"/> c. Legal Guardian | Relative & Guardian        | 5         |
| <input type="checkbox"/> d. Other          | Parent Only                | 14        |
|  | Relative Only              | 4         |
|  | Guardian Only              | 7         |
|  | <b>TOTAL</b>               | <b>51</b> |

2. How did you learn about the opportunity to consider a community placement? (check all that apply)

- |  |    |
|--|----|
| <input type="checkbox"/> a. Letter from the institution  | 22 |
| <input type="checkbox"/> b. Parent Group meeting         | 7  |
| <input type="checkbox"/> c. Newsletter                   | 4  |
| <input type="checkbox"/> d. Discussions with state staff | 36 |
| <input type="checkbox"/> e. Don't remember               | 0  |
| <input type="checkbox"/> f. Other (please specify)       | 8  |

Comments refer mostly to phone calls.

3. Which statement best describes your level of involvement in important decisions about moving from the institution.

- |   |    |
|---|----|
| <input type="checkbox"/> a. I was significantly involved and made the decisions       | 33 |
| <input type="checkbox"/> b. I was consulted on decisions and informed of the progress | 15 |
| <input type="checkbox"/> c. I was minimally involved                                  | 2  |
| <input type="checkbox"/> d. I was not involved.                                       | 1  |

4. If you were not involved, what was the reason?

- |   |   |
|---|---|
| <input type="checkbox"/> a. I did not wish to participate                           | 0 |
| <input type="checkbox"/> b. I could not participate because of health, travel, etc. | 7 |
| <input type="checkbox"/> c. I was not asked to participate                          | 1 |
| <input type="checkbox"/> d. Other (please specify)                                  | 1 |

5. At any time did you feel pressured by state staff about whether to move or not move your family member out of the institution?

- |                                      |                          |
|--------------------------------------|--------------------------|
| <input type="checkbox"/> a. Yes      | 8 - See comments at Q 6. |
| <input type="checkbox"/> b. No       | 43                       |
| <input type="checkbox"/> c. Not sure | 0                        |

6. If you answered yes to question 5, please explain.

### Eight respondents made comments:

1. Institution gave away bed on day of move.
2. State said community placement better.
3. Was pressured on phone; move was made before consent form was signed.
4. Felt compelled to move now before move is mandatory.
5. Staff seemed in a rush to move him.
6. Staff brushed aside mom's questions.
7. Unclear comments.
8. Unclear comments.

7. From the institution, what type of living arrangement did your family member move into?

- ☐ a. Group home
- ☐ b. Tenant Support (please circle one of the following)
- private intensive tenant support (ITS)
  - state operated living arrangement (SOLA)
  - don't know
- ☐ c. Your home or other relative's home
- ☐ d. Adult Family Home
- ☐ e. Don't know
- ☐ f. Other (please specify)

---

Thirty-eight of 51 correctly identified the type of living arrangement.

---

8. Since leaving the institution, has your family member moved again?

- ☐ a. No, still in same place 46
- ☐ b. Moved one more time 5
- ☐ c. Moved two or more times 0

9. Is it important to you that attendant care services at the house or apartment be provided by a state employee (rather than an employee of a private organization under contract to the state)?

- ☐ a. Yes 16, of which 14 live in SOLAs.
- ☐ b. No 26
- ☐ c. Don't know 8
- No response = 1

10. If you answered yes to question 9, please specify why.

**Summary of Comments:**

State service is more dependable, more experienced, less staff turnover, and no profit motive.

---

11. Did you tell the state staff that you preferred a state-operated living arrangement (SOLA), in which the attendant care staff are state employees?

- ☐ a. Yes 20 "Yes" to both
- ☐ b. No 27 Q 11 and Q 12 = 10
- No response = 4

12. If you answered yes to 11, were you only willing to consider a SOLA?

- ☐ a. Yes 10
- ☐ b. No 17

13. At any time did you feel pressured by state staff about the type of living arrangement to choose for your family member?

- ☐ a. Yes 3
- ☐ b. No 47
- ☐ c. Not sure 1

14. If you answered yes to question 13, please explain.

1. Felt pressured to move from one-person apartment to house.
  2. Felt there were no choices.
  3. Moved too quickly, to beat deadline.
- 

15. What needs and preferences were important in your final decision about where to move your family member? (Mark the most important with "1". Mark others of importance to you with an "x").

- > See note below.
- ☐ a. Being able to tour the specific house, apartment, etc. where the family member would live. 39
- ☐ b. That the family member would be able to live with the roommate(s) of choice. 18
- ☐ c. Meeting and liking the staff who would support the family member in their new home. 35
- ☐ d. State staff thought this would be the best place. 15
- ☐ e. The location of the house or apartment 36
- ☐ f. That the family member would have the opportunity to be part of the community 40
- ☐ g. How long the provider had been in operation 11
- ☐ h. Stability of funding and staffing 32
- ☐ i. Program meets unique or specialized needs 40
- ☐ j. Other (please specify) 2
- 

Note: Tally shown is of all items that were marked. Few respondents distinguished between the most important reason ("1") and other reasons ("x").

---

16. Before the move, did state staff provide you with opportunities to learn about housing choices available to your family member?

- ☐ a. Yes 37  
☐ b. No 9  
☐ c. Don't know 1 No response = 4

17. Did state staff provide you with opportunities to learn about job/school/day program choices for your family member before the move?

- ☐ a. Yes 32  
☐ b. No 13  
☐ c. Don't know 1 No response = 5

18. How well informed do you feel about the choices for living arrangements available in your area for your family member?

- ☐ a. Well Informed 31  
☐ b. Somewhat Informed 10  
☐ c. Not Informed 5  
☐ d. Don't know 1 No response = 4

19. How well informed do you feel about the choices for day programs available in your area for your family member?

- ☐ a. Well Informed 18  
☐ b. Somewhat Informed 20  
☐ c. Not Informed 6  
☐ d. Don't know 2 No response = 5

20. Would a directory that lists services available in your area for people with developmental disabilities help you to be better informed?

- ☐ a. Yes 30  
☐ b. No 9  
☐ c. Don't know 7  
 No response = 5

21. If you answered yes to question 20, what services should be included in the directory (please specify)

22 respondents (out of 30 "yes") mentioned the following services:

Recreation	-- 13	Residential	-- 2
Jobs	-- 10	Transportation	-- 2
Services (unspecified)	-- 4	Therapy	-- 2
Medical/Dental	-- 3	Church	-- 1
Phone Numbers	-- 3		

22. Was there sufficient attention given to your family member's needs and preferences before the move?

- ☐ a. Yes 40  
☐ b. No 2  
☐ c. Don't know 4 No response = 5

23. Was there sufficient attention given to your needs and preferences before the move?

- ☐ a. Yes 42  
☐ b. No 4  
☐ c. Don't know 1 No response = 4

24. How satisfied were you with the planning by state staff for this move?

- ☐ a. Very Satisfied 36  
☐ b. Somewhat Satisfied 8  
☐ c. Neutral 0  
☐ d. Somewhat Dissatisfied 2  
☐ e. Very Dissatisfied 1  
 No response = 4

---

One "very dissatisfied" = they took away his medicine.

---

25. How satisfied were you with the help given your family member to prepare for this move?

- |   |    |
|---|----|
| <input type="checkbox"/> a. Very Satisfied        | 41 |
| <input type="checkbox"/> b. Somewhat Satisfied    | 5  |
| <input type="checkbox"/> c. Neutral               | 3  |
| <input type="checkbox"/> d. Somewhat Dissatisfied | 0  |
| <input type="checkbox"/> e. Very Dissatisfied     | 0  |

---

No response = 2

---



---



---



---

26. Overall, how satisfied are you with the place where your family member is living?

- |   |    |
|---|----|
| <input type="checkbox"/> a. Very Satisfied        | 42 |
| <input type="checkbox"/> b. Somewhat Satisfied    | 6  |
| <input type="checkbox"/> c. Neutral               | 2  |
| <input type="checkbox"/> d. Somewhat Dissatisfied | 1  |
| <input type="checkbox"/> e. Very Dissatisfied     | 0  |

---

One "somewhat dissatisfied" -- problem with neighbor.

---



---



---



---

27. Overall, how satisfied are you with what your family member does during the day?

- |   |    |
|---|----|
| <input type="checkbox"/> a. Very Satisfied        | 33 |
| <input type="checkbox"/> b. Somewhat Satisfied    | 9  |
| <input type="checkbox"/> c. Neutral               | 5  |
| <input type="checkbox"/> d. Somewhat Dissatisfied | 1  |
| <input type="checkbox"/> e. Very Dissatisfied     | 1  |

No response = 2

Seven comments:

No job	4
Pleased with job	1
No transportation	1
Wants more structured activities	1

---

28. How would you compare your family member's current living situation with the institution?

- |  |    |
|--|----|
| <input type="checkbox"/> a. Much Better      | 35 |
| <input type="checkbox"/> b. Better           | 7  |
| <input type="checkbox"/> c. The Same         | 2  |
| <input type="checkbox"/> d. Worse            | 0  |
| <input type="checkbox"/> e. Much Worse       | 0  |
| <input type="checkbox"/> f. Too Soon to Tell | 4  |

No Response = 3

---

Seventeen comments about client improvement.  
Two comments about too soon to tell.

---



---



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---



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29. Is there anything else you would like to say about moving your family member or their current situation (e.g., medical care, transportation, moving delays?)

Twenty-eight comments; most very favorable.

**Appendix 3**  
**AGENCY RESPONSE**

RICHARD J. THOMPSON  
Secretary



STATE OF WASHINGTON  
DEPARTMENT OF SOCIAL AND HEALTH SERVICES  
Olympia, Washington 98504-0095

January 7, 1991

RECEIVED

JAN 8 1991

LEGISLATIVE  
BUDGET COMM

Cheryle A. Broom, Legislative Auditor  
Legislative Budget Committee  
506 East 16th, MS: KD-11  
Olympia, Washington 98504

Dear Cheryle:

Thank you for the opportunity to provide comments about the LBC study report on Residential Services for Clients with Developmental Disabilities. The report was thorough for the information gathered during phase 1 and represented the complexity of the issues. We appreciate the professionalism of the LBC staff who worked on this study.

Our response for each recommendation is as follows:

<u>Recommendation</u>	<u>Agency Position</u>	<u>Comments</u>
1	CONCUR	
2	CONCUR	
3	CONCUR	

We look forward to continuing our positive working relationship during the next phase.

Thank you.

Sincerely,

A handwritten signature in cursive script, appearing to read "Sue Elliott".

Sue Elliott, Director  
Division of Developmental Disabilities





State of Washington  
Legislative Budget Committee

---

# **RESIDENTIAL SERVICES FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES - PHASE II**

## **Report 92-1**

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January 13, 1992

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# RESIDENTIAL SERVICES FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES - PHASE II

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## Summary

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**T**his report is an overview of state programs and services for people with developmental disabilities (DD). The main focus is on residential placements. The report reviews the DD system, identifies outstanding policy issues, discusses federal Medicaid funding for DD programs, and reports on innovative approaches in other states. No recommendations are made in this report. Further analytical work is scheduled for 1992.

The report originated in part out of the following concerns:

- State statutes provide little direction on a wide range of DD issues.
- Policy directions and priorities are heavily influenced by short-range budget decisions that can change every two years or more frequently.
- The state has no long-range plan for developmental disabilities. The Department of Social and Health Services (DSHS) has started a planning process, but it may be difficult to produce a long-range plan without policy direction by the legislature.

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Origins of  
the study

## BACKGROUND

Under state law a "developmental disability" is a disability attributable to mental retardation, cerebral palsy, epilepsy, autism, or another neurological or other condition closely related to mental retardation. The disability must originate prior to age 18, be expected to continue indefinitely, and be a substantial handicap to the individual.

---

## Statutes are ambiguous

The statutes authorize DSHS to "develop and coordinate state services" and "cooperate with communities" to establish "locally administered and locally controlled" services. The statutes are often general. While DSHS is directed to serve all eligible persons within the limits of available funding, the statutes do not set service priorities. The statutes provide little policy direction on where, how, and to what extent people with DD should be served. However, the statutes do direct DSHS to operate the six state institutions for the developmentally disabled, which are "permanently established."

---

## How many people are served?

As of December 1991, about 16,700 people were eligible for services from programs operated or funded by the DSHS Division of Developmental Disabilities. The report includes figures on the number of people served in various programs, but the figures are not unduplicated across programs. Thus it is unclear from reports currently available how many of the 16,700 eligible clients actually are served and how many are unserved or under-served. However, case managers have long "waiting lists" for residential placements, family support, and employment and day programs.

People with DD may also receive services from other systems, such as children's services, aging programs, and special education. The report includes the best figures available on people with DD served by those programs.

## POLICY ISSUES

To identify outstanding DD policy issues, legislative staff organized two "focus group" discussions. The participants were 30 leaders from a broad range of DD organizations and 22 staff from six state agencies. We also interviewed representatives of the two unions that represent employees at the state DD institutions. The purpose was to identify issues for consideration by the state in long-range planning.

The report includes a summary of issues from the focus groups and the union interviews (pages 11-18). The long list of issues suggests that, in the view of many focus group participants, the current DD system is too complex, uncoordinated, inequitable, and possibly in need of structural changes and policy development by the legislature.

## SELECTED ASPECTS OF WASHINGTON DD PROGRAMS

Chapters 3 and 4 include descriptions and some analysis of the following:

- The state DD institutions, including comparisons with other states.
- Community residential placements.
- Limitations of the available data, especially on DD community services.
- Problems in comparing costs of institutional and community placements.
- Services to families with a DD child or adult at home.
- The Medicaid "home and community based waiver" that provides federal funds to support people living at home or in other community settings.

### ICF/MR Program

The report discusses Intermediate Care Facilities for the Mentally Retarded (ICF/MR), which are annually certified to receive federal Medicaid funding. The program currently includes five of the six state DD institutions and 24 private nursing facilities and group homes. The charts on page 23 show relevant data since 1987. Like many states, Washington is reducing its reliance on ICF/MR placements because of problems in meeting certification standards and rising institutional costs.

---

Decline of  
ICF/MR  
placements

### Community Residential Placements

The report describes the various types of community residential placements. Placement trends are shown in the graph on page 20. Recent state budgets have included funding to decrease the population of the state institutions and to expand community residential placements. Between December 1989 and December 1991, about 415 people were transferred to community residential placements from either the state institutions or similar contracted facilities.

---

Transfers to  
community  
placements

## **Data Problems**

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### **Better data needed for policy making**

The report discusses limitations of the available data on developmental disabilities, especially the programs and services funded in the Community Services section of the DD budget. Much of the information is limited by confusing terminology, inconsistent definitions, and fragmented data categories. To provide clear information useful for policy making, a review of the DSHS data systems on DD may be needed. It would be helpful if this topic were addressed as part of the developmental disabilities long-range planning effort.

## **Cost Comparisons**

We plan to report fully on cost issues next year. This report includes an introduction to the subject (pages 26-28). Close attention must be given to identifying all the cost components in institutional and community settings.

---

### **Comparison problems**

It is misleading to compare state institution per diem costs with the daily contract rate for a community residential placement, because the service packages are not comparable. We also question the common assumption that the transfer of relatively small numbers of institutional residents to "lower cost" community placements will lead to cost savings. The total institutional costs remain about the same, and new costs are incurred for contracted community services. The net effect is higher overall expenditures.

## **Services to Families: The Equity Issue**

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### **Equity issue**

Most people with DD live at home with their parents, relatives, or a guardian, or live in their own homes. The report discusses the apparent imbalance in the current system between funding and persons served. The relatively few people who live in the state institutions or community residential programs receive extensive services that consume a disproportionate amount of available funding, while families who care for a DD person at home are provided relatively few services. This disparity between the distribution of funding and clients is known as the "equity issue."

The report discusses why the equity issue persists. According to DSHS sources, some influential factors are as follows:

- It is difficult to reduce the level of services for persons already in residential placements (institutions and community placements).
- In contrast, the non-residential community programs and support services receive little federal funding. These programs or services include those of most interest to families caring for a disabled member at home (such as Family Support, employment and day programs, and case management). In the budget process these services tend to be reduced first and increased last in order to conserve state general fund dollars and/or avoid the loss of federal funds for other programs.
- The state budget may prohibit "new" services by DSHS and require offsetting state general fund reductions for any additional federal funds received. DSHS fiscal staff indicate that the budget language discourages the agency from attempting to reach unserved or under-served individuals.

## Medicaid Waivers

Under Medicaid "home and community based waivers," states with approved waiver programs are permitted to use Medicaid matching funds to support certain people with DD in home and community settings. This includes former residents of the state institutions and other persons eligible for institutional care for whom it is more cost-effective to provide services at home or in a community residential placement. Of the three waiver programs currently in effect, the major one is known as the Community Alternatives Program (CAP).

For 1991-92 the CAP waiver authorizes DSHS to receive up to \$34.6 million in federal funds. After state matching funds are added, this waiver program could provide up to \$63 million per year for DD services. If a similar amount is authorized for 1992-93, the waiver would represent about 20 percent of the DD budget.

Washington had one of the first waiver programs in the country (since 1983), but it has fallen behind other states in utilizing the waiver to the fullest extent. As of June 1990, Washington ranked

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Home and  
community  
based waivers



18th in the nation (out of 44 states with waiver programs) in waiver recipients per unit of state population.

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### Opportunity for better use of waivers

It appears that DSHS could make greater use of the CAP waiver by:

- Filling all of the "slots" available under the current waiver. About 462 waiver slots, or 20 percent of the authorized limit, are unfilled as of December 1991. The current waiver expires in April 1992.
- Renewing and modifying the waiver to increase the number of authorized slots, amount of funding, and kinds of authorized services.

Washington and probably all states with waiver programs use the waiver funding primarily to support DD persons in community residential placements (placements in which the primary care givers are paid staff). However, according to survey data, the waiver recipients in many other states include a higher proportion of families who care for a disabled person at home. Another contrast is that many states have successfully applied to receive matching waiver funds for supported employment, but it is not an authorized service under the Washington waiver. (DSHS indicates that additional services will be requested under the CAP waiver renewal due in April 1992.)

It is important to note that any significant expansion of family-related services with waiver funding would require additional state matching funds.

## INNOVATIVE APPROACHES IN OTHER STATES

We collected information from three states reputed to have "progressive" DD systems or at least innovative programs worth exploring, as opposed to being "representative" or "typical" states. The states are New Hampshire, Michigan, and Wisconsin. The material is incomplete because of the short time available for research. In our work scheduled for 1992, we plan to develop some of the following information and to explore innovative approaches in other states.

## **New Hampshire**

New Hampshire has a community-based DD system without institutions. The one state DD institution was closed in January 1991, the culmination of a long process of "downsizing" the institution and building a community services system. The report discusses some key aspects of this process.

New Hampshire's DD system is decentralized and based on 12 regional Area Agencies. Roughly 90 percent of the funds appropriated to the New Hampshire state DD agency are contracted to the Area Agencies. They provide all specialized DD services, either directly or through contractors. The New Hampshire system offers many contrasts to the more centralized and complex system in Washington.

We compared DD funding in New Hampshire and Washington in terms of dollars per state resident. The total appropriations are almost the same, but the distribution is quite different. Community residences, employment and day programs, and family support services have far higher funding levels in New Hampshire. The fiscal data are consistent with survey findings that New Hampshire surpasses Washington in the rate of community residential placements, supported and competitive employment, and other services for people with DD.

## **Michigan**

The report describes aspects of Michigan's DD system, mainly the cash subsidy program which provides grants of \$222 a month to defray the costs of maintaining a DD child at home. The Michigan system emphasizes family and community services. Two of the five state DD institutions were closed recently. The state has announced plans to close the remaining institutions by 1994. Residents will be transferred to community placements.

## **Wisconsin**

The report discusses Wisconsin's family support services for severely disabled children. The program offers a wide variety of services to families who maintain a child with DD at home, with a

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**New  
Hampshire  
DD system**

---

**Cash grants in  
Michigan**

high degree of parental control over the kinds of services and when they are provided. In Washington, in contrast, respite care is the predominant service, and parents have less control over what services are provided and when they are available.

## ACKNOWLEDGEMENTS

Matt Temmel and Frank Hensley of the LBC staff conducted most of the research and prepared the report. Cheryle Broom, Legislative Auditor, was the project supervisor. Jonnel Anderson, Senior Research Analyst on the staff of the Senate Republican Caucus, conducted the research on Michigan and Wisconsin that appears in the last chapter of the report.

We are grateful for the help of House and Senate legislative staff in organizing the "focus group" discussions to identify outstanding policy issues.

We also appreciate the cooperation and assistance of staff in the Division of Developmental Disabilities and other parts of the Department of Social and Health Services. They were responsive in providing information for the report and in answering our many questions. A letter from the agency appears on the last page of the report.

Cheryle A. Broom  
Legislative Auditor

*On January 13, 1992, this report  
was approved by the Legislative  
Budget Committee and its distribu-  
tion authorized.*

Senator Gerald Saling  
Chair

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# SCOPE AND OBJECTIVES

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## *Scope*

This study addresses public policy issues related to residential placements and other services for persons with developmental disabilities (DD). The goal is to identify policy options for legislative consideration as a possible basis for long-range planning.

## *1991 Study Objective*

1. Review the status of state programs and policies.
  - a. Briefly describe current DD programs, clients, and funding.
  - b. Identify major issues affecting persons with developmental disabilities on which policy development is needed to form a basis for long-range planning.
  - c. Develop comparative data on key features of DD services in Washington and selected other states, and identify innovative approaches in other states.
  - d. Review the federal funding available for DD programs, including institutions and community placements.

## *Note*

This report covers the first objective (above). Research is scheduled to continue on objectives 2 and 3 (on the following page) and be reported in briefings during 1992 and in a report scheduled for September 1992. Objectives 2 and 3 are subject to revision.

*1992 Tentative Study Objectives*

2. Analyze the feasibility of expanding community residential placements.
  - a. Examine the availability of residential placements and necessary related services.
  - b. Analyze costs, funding sources, and program allocations; identify options.
  - c. Review data on institutional residents and community resources to determine how many residents could be transferred to community residential placements.
  - d. Identify options for state employees if institutional populations are significantly reduced.
  - e. Review available standards in residential placements, including criteria for judging program effectiveness and quality.
3. Analyze how to achieve a more cost-effective use of current resources and a more equitable distribution of DD funding and services.
  - a. Review information on the client characteristics of persons on the waiting list for DD services.
  - b. Evaluate the feasibility of developing more economical types of community placements and family support, including the positive and negative aspects associated with cost, service, and management.

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# BACKGROUND

## Chapter One

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**T**his report is an overview of state programs and policies for people with developmental disabilities (DD). The main focus is on residential placement issues. The report reviews the current DD system, identifies outstanding policy issues, reports on innovative approaches in other states, and analyzes federal funding for DD programs.

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### Overview

The report is a prelude to in-depth analysis of DD issues scheduled for 1992. First, further work is planned by the LBC staff, as shown in the Scope and Objectives on the previous page. Second, the Department of Social and Health Services (DSHS) will prepare a long-range plan on developmental disabilities. The DSHS long-range planning effort is independent of the LBC study, although the staffs will try to coordinate by avoiding duplicative research and sharing information as appropriate.

According to state statute, RCW 71A.10.020, a "developmental disability" is a disability attributable to mental retardation, cerebral palsy, epilepsy, autism, or another neurological or other condition closely related to mental retardation. The disability must originate prior to age 18, be expected to continue indefinitely, and be a substantial handicap to the individual. A mentally retarded person is eligible for services if he or she has an IQ of 69 or less and significant deficits in adaptive behavior.

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### What is a developmental disability?

The state definition of DD covers a more limited population than the broader, permissive definition in federal law. For example, the federal definition could include persons with traumatic brain injury or fetal alcohol syndrome without requiring that the person be

diagnosed as mentally retarded. The other major difference is that federal law requires onset of the disability prior to age 22, as opposed to age 18 under state law.

---

How many  
people are  
served?

As of December 1991, about 16,700 people were eligible for services from programs operated or funded by the DSHS Division of Developmental Disabilities. Service counts are available from the various programs, but they are not unduplicated across programs. Thus it is unclear from reports currently available how many of the 16,700 eligible clients actually are served and how many are unserved or under-served. (DSHS staff indicate that special data runs could be done to obtain unduplicated counts of the number served and unserved at a point in time.) However, case managers have long "waiting lists" for residential placements, family support, and employment and day programs.

## STATE POLICY

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State statutes  
are  
ambiguous

RCW 71A.12.010 authorizes DSHS to "develop and coordinate state services" for persons with DD and to "cooperate with communities" to establish services that are "locally administered and locally controlled." The statute stipulates that services "should be planned and provided as part of a continuum" and that a "pattern of facilities and services" should be established. DSHS operates the six state DD institutions, which are "permanently established" under RCW 71A.20.020. Other key statutes in Title 71A give DSHS authority to contract for services and allocate funds to counties. The agency is directed under RCW 71A.12.020 to provide needed services to every eligible person within the limits of available funds.

As suggested by the above excerpts, the state statutes on DD are general. The statutes provide little policy direction on who should be served and where, how, and to what extent they should be served. While DSHS is directed to serve all eligible persons within the limits of funding, the statutes do not set priorities as to who should be served first. Perhaps a key "message" in the state statutes is that DD services must be "coordinated" between the various agencies and organizations involved in delivering services.

## SPECIALIZED SERVICES

Specialized services for people with DD are the responsibility of the DSHS Division of Developmental Disabilities. The division is funded with appropriations totalling \$640 million for the 1991-93 biennium. This figure is based on the initial allotments and excludes the reductions implemented on December 1, 1991, and others that may be decided in 1992. All figures for the 1991-93 biennium cited in this report are based on the initial allotments.

Exhibit 1 on the next page illustrates the state system of specialized DD programs and services. The division provides direct services by state employees as follows:

- The six state DD institutions, known as Residential Habilitation Centers, with about 1,544 residents as of December 1991. Five of the six institutions currently participate in the Intermediate Care Facilities for the Mentally Retarded (ICF/MR) program, a Medicaid program with federal and state matching funds.
- The "SOLA" program (State Operated Living Alternatives), with about 68 residents transferred from the state institutions as of December 1991. SOLAs provide 24-hour staffing, which is the same level of care as in contracted Intensive Tenant Support programs.
- The Division of Developmental Disabilities Field Services offices, which provide case management and other services for people with DD, most of whom live at home or in other community settings.

The other programs or services shown in Exhibit 1 are provided under contract. The contracted residential programs include:

- Twenty-four private residences that participate in the ICF/MR program, including five nursing facilities and 19 small group homes.
- Community residential programs with various levels of staffing requirements. The programs include Group Homes, Tenant Support, and Intensive Tenant Support.

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### Direct state services

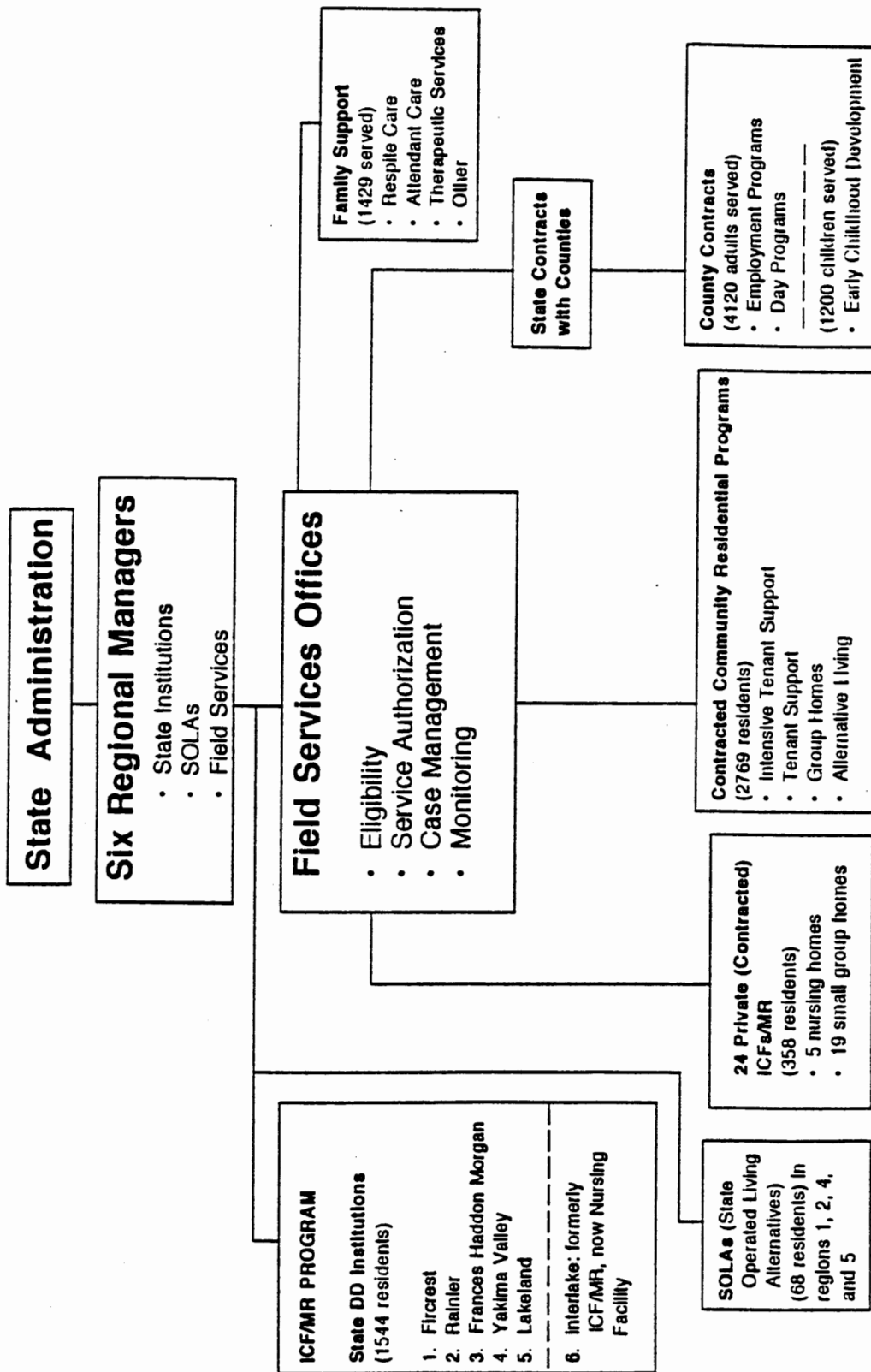
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### Contracted services



# Washington State Department of Social and Health Services DIVISION OF DEVELOPMENTAL DISABILITIES (16,700 eligible clients)

Exhibit 1



Note: Numbers are approximate client counts as of December 1991 or the latest available month.

Source: LBC Staff

- Alternative Living, a residential support program for persons who live in their own homes and receive help in activities such as money management and meal preparation.

According to the Division of Developmental Disabilities, the above contracted programs served a total of 2,769 persons in December 1991.

Family Support services are also provided under contract. The term "family support" covers a variety of services needed to maintain a person with DD in the home of parents, relatives, or a guardian. Typical services include respite care, attendant care, therapy, and temporary staff to deal with emergency situations. In October 1991 a total of 1,429 persons received Family Support services. The vast majority of clients are children.

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Family  
support

Many community services to people with DD are funded through state contracts with the counties. The counties in turn contract with private organizations to provide employment and day programs and other services. In December 1991, according to the Division of Developmental Disabilities, about 4,120 adults received employment or day programs. Some of these people live in state-supported residential placements (such as Group Homes, Tenant Support, Intensive Tenant Support, or SOLAs). The others live in their own homes or with parents, relatives, or a guardian.

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County  
contracts

## OTHER SERVICES

People with developmental disabilities may receive services through many other government agencies and programs. Exhibit 2 on the next page shows some of the agencies involved in serving people with DD.

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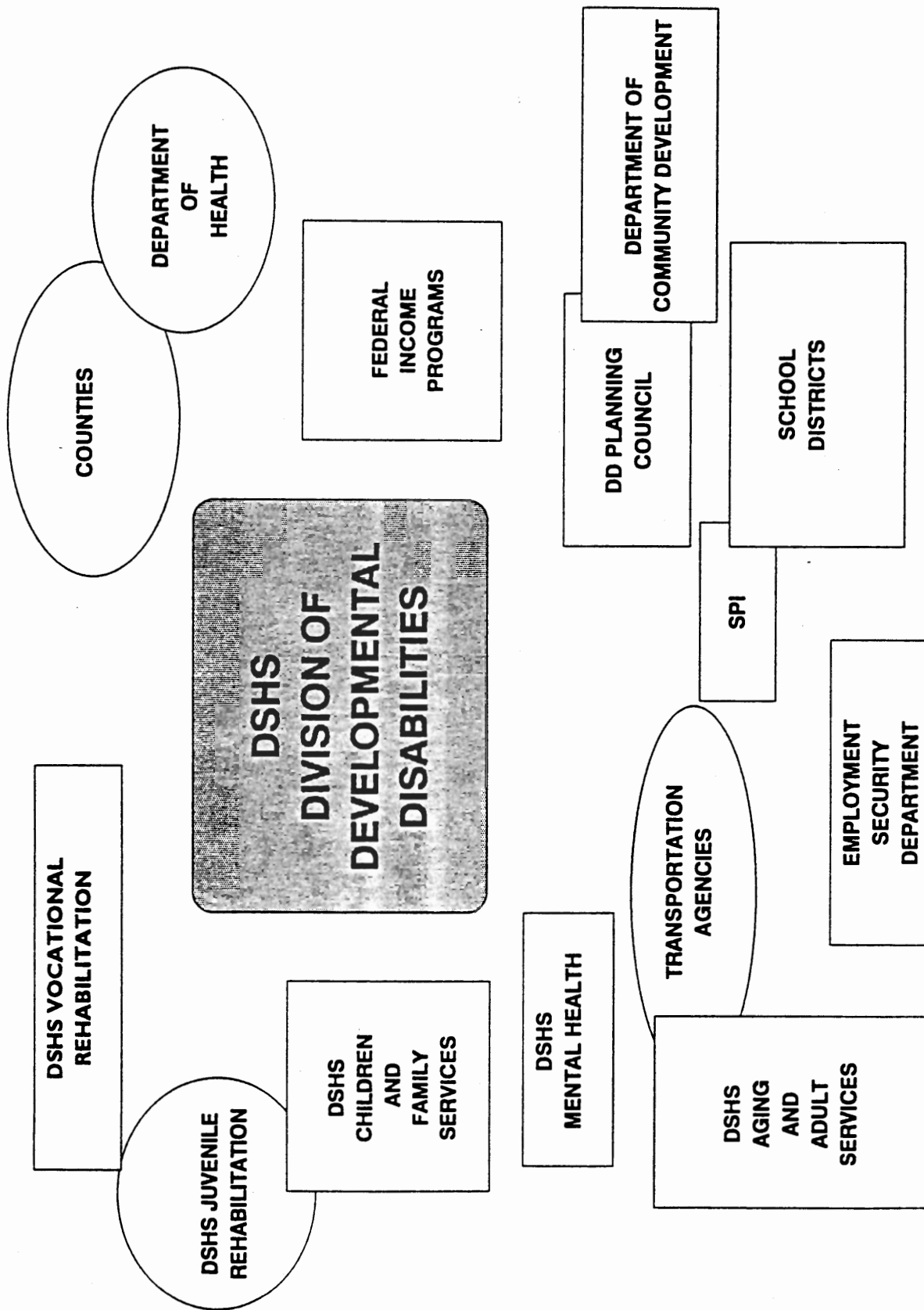
How many  
people are  
served by  
other  
systems?

It is difficult to ascertain the number of people with DD served through the agencies shown in Exhibit 2. We examined various data sources and obtained the following counts or estimates for September 1991. With the exception of special education, the figures are from DSHS sources.

- About 578 children with DD were placed in foster care.
- About 53 people with DD were residents in the state's mental health institutions (Western and Eastern State Hospitals).

Exhibit 2

# SOME GOVERNMENT AGENCIES SERVING PEOPLE WITH DEVELOPMENTAL DISABILITIES



- Some 2,013 people with DD were served by DSHS Division of Aging programs, including chore services, adult family homes, congregate care facilities, Title XIX Personal Care, and COPEs (Community Options Program Entry System). The figure excludes an indeterminate number of people with DD living in nursing homes and others served by community senior programs funded by the Area Agencies on Aging.
- Some 6,000 to 7,000 children with developmental disabilities, as defined by the state, are served by school district special education programs. This is seven to eight percent of the 84,805 students enrolled in special education during the 1990-91 school year.<sup>1</sup>

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DD children  
are a small  
part of special  
education

## ORGANIZATION OF THE REPORT

Chapter 2 is a list of outstanding policy issues in the field of developmental disabilities, for consideration by the state in long-range planning.

Chapter 3 reviews the ICF/MR program and community residential placements. The chapter also discusses limitations of the available data on community programs and problems in comparing the costs of institutional and community placements.

Chapter 4 reviews other aspects of Washington DD programs, including family support and Medicaid home and community based waivers. That chapter also discusses the impact of federal funding on DD programs.

Chapter 5 compares aspects of the Washington DD system to innovative systems and programs in other states, namely New Hampshire, Michigan, and Wisconsin.

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<sup>1</sup> Estimate by LBC staff, based on 1990-91 reports of special education enrollment by handicap category. This estimate coincides with information from the Division of Developmental Disabilities that 6,912 of its eligible clients were age 21 or under as of November 1991.

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# POLICY ISSUES

## Chapter Two

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**T**his report originated in part out of the following concerns:

- State statutes provide little direction on a wide range of DD issues.
- Policy directions and priorities are heavily influenced by short-range budget decisions that can change every two years or more frequently.
- The state has no long-range plan for developmental disabilities. A planning process has now begun, but it may be difficult to produce a long-range plan without policy direction by the legislature.

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### Overview

An objective of the report is to identify outstanding DD policy issues. To accomplish this purpose, legislative staff conducted two "focus group" sessions in September and October 1991. The participants at the first session included 30 leaders of organizations interested in DD issues. The second session was attended by 22 staff from six state agencies which serve people with DD.

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### Focus groups

The participants addressed the following question:

**What are the long-range planning issues  
that the state should consider?**

The same question was addressed in interviews conducted with representatives of the two unions at the DD state institutions. The unions are the Washington Federation of State Employees, which represents most institutional employees, and the National Union of

Hospital and Health Care Employees, Service Employees International Union #1199, which represents registered nurses.

The issues identified by the focus groups and the union representatives ran to 33 pages of typed material. Legislative staff later summarized the material, as presented below.

The issues are in seven categories: (1) systems planning issues, (2) protection, (3) housing, (4) health care, (5) education, (6) social contribution, and (7) families and children. The list of issues is not prioritized—that is, the issues that appear first are not necessarily the most important. However, the summary does include a “preamble” of points considered most important by the September focus group.

## **SUMMARY OF FOCUS GROUP DISCUSSIONS**

### **Preamble**

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Reexamine  
basic  
assumptions  
and goals

The assumptions and goals of the current DD system should be reexamined. The state’s primary goal should be the “empowerment” of people with developmental disabilities so that they have as much control over their own lives as possible. Resources, including funding, should be tied to individuals with DD so that people rather than programs drive the system. The state should shift from a “professionally-based” to a “personally-based” system. The new system should increase individual, family, and community capacity to support people with DD.

### **Systems Planning Issues**

- The long range plan should clearly define the population, address the prevalence and diversity of disabilities, and recognize new conditions (such as fetal alcohol syndrome and AIDS) not covered in current state rules. Moreover, the plan should recognize changing demographics such as the number of senior citizens and ethnic minorities with DD.
- The current “system” is fragmented and is actually many systems. Major structural changes should be considered.

- The role of the many state agencies currently involved in providing services should be examined and clarified. The agencies include DSHS Division of Developmental Disabilities, DSHS Division of Children and Family Services, DSHS Division of Aging, DSHS Division of Mental Health, DSHS Division of Juvenile Rehabilitation, DSHS Division of Vocational Rehabilitation, Department of Corrections, Department of Health, Department of Community Development, Employment Security Department, and Superintendent of Public Instruction. How can coordination be improved?
- The plan should examine how the "generic" service systems (such as foster care, child protective services, aging, mental health, and others) provide services to people with DD. Consider changes needed in those systems to give easier access and also to serve persons who are dually diagnosed. Make provision for staff training in the generic systems.
- Develop an appropriate balance between generic and specialized delivery systems. Consider whether the current focus on specialized services is encouraging people with DD to stay out of the mainstream.
- Redefine DD "services" as supports to the individual and family. Consider shifting from government funding of centrally defined services toward increasing the community supports, utilizing generic support services available in local communities, and possibly to a voucher system so families can purchase the services they need.
- The plan should reconsider the use of state facilities, staff, and fiscal resources to enhance the community capacity to support families and individuals.
- The plan should address how to develop the community capacity for all needed supports, such as medical services, jobs, and housing, rather than just allocating dollars for supports that have not been developed.
- The plan should consider who should receive state support, the trade-offs between quality and quantity of service, and priorities.

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Improve  
coordination  
of services

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Reconsider  
the use of  
state facilities,  
staff, and  
funds

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### Who should make the key decisions?

- The plan should reconsider where and how decisions are made regarding funding allocations, services to be provided, who is served, etc. What are the benefits and risks of changing the locus of control?
- What is the role of case management services?
- The plan should reconsider the allowable and desirable extent of local variation in service availability and provision.
- Birth to death supports are needed in many cases. The plan should provide for continuity of care and give assurance of ongoing support if needed. Also recognize that service needs can change, and that many people with DD need only occasional support.
- The plan should clarify the basis for provider payment and establish a cost-effective and equitable payment system.
- The plan should address the problem of employee turnover in community programs and consider wage equity with state employees.

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### Contradictions in current system

- Investigate the contradictions in the current system of simultaneously offering "open-ended entitlement services" and "limited and capped services." Determine what effect this system has on the ability of any agency or provider to offer cost-effective, efficient, and coordinated service choices to individuals and families with disabilities. Does the current system force individuals into services they do not need, because they are not eligible for the ones they do need, or are prevented from receiving them because they are capped?
- Consider how to accomplish an equitable distribution of services within the current funding restrictions. Are there ways to increase resources for those on "waiting lists" by decreasing resources to others, or by developing new ways of providing needed supports?
- Consider devoting funding increases to the unserved population rather than to enhancing programs for those currently served.



- Determine whether institutional downsizing is absorbing community resources to the disadvantage of the unserved or under-served populations. Investigate the side effects of downsizing. Does it promote greater use of other systems, e.g., the state mental hospitals?
- The plan should contain mechanisms to manage program expansion and contraction as needed and set priorities due to limited resources.
- The plan should be phased in, contain provisions for updating, and contain provisions for "system self-correction" through ongoing consumer reviews and outside professional evaluations.

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More system  
planning  
issues

### Protection: Safety and Security

- Promote safety, security, dignity, and protection from indignities.
- Assure that staff are well trained.
- Determine what Quality Assurance standards can be applied to all services to ensure protection.
- Examine guardianships and determine if they are appropriately used to protect the rights of the individual and their family.
- Ensure independent and responsible advocacy for people with DD.
- Besides protecting the individual with DD, recognize the public need for protection from those who are a danger to others.

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Protection  
issues

### Housing

- Consider how to increase the supply.
- Reduce licensing inconsistencies and red tape in residences for people with DD. Have consistent and practical licensing requirements.

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## Housing issues

- Address zoning and building code restrictions. Make it easier to locate group homes in appropriate locations.
- Provide in-home supports which are individually tailored and promote self-sufficiency, such as attendant care and chore services.
- Determine how the state could better use the property on which the state institutions are located to support increased housing options.
- Determine the capital needs of the state institutions.
- Consider ending the admissions freeze at the state institutions. Consider stopping downsizing.
- If downsizing continues, consider the state's commitment to state employees. Find options that are productive for the employees and residents.

## Health Care

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## Health care issues

- Consider using the state institutions to provide medical and dental care for community residents.
- Increase the availability of health care providers who have the skills to treat people with DD. For example, provide training for University of Washington medical and dental students at the RHCs or other settings where they can learn the necessary skills.
- Improve access to specialized health treatments such as speech therapy and occupational therapy.
- Increase prevention and early intervention efforts, and improve coordination.

## Education

- Encourage mainstreaming of DD students in the K-12 system.

- Teacher training at the universities lags behind the field. Update training curriculums.
- Increase prevention and early intervention efforts.
- Improve life-skills and vocational training for disabled students.
- Improve transition planning for disabled students.

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## Education issues

### Social Contribution

- Develop community capacity for DD employment programs. Don't just allocate dollars for work program slots that do not exist.
- Develop more supported employment opportunities. Employment Security Department staff should work with employers or train Division of Developmental Disabilities staff to work with employers.
- Consider using the state institutions for work and day programs for community residents.
- Develop neighborhood and community support systems to encourage integration.

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## Employment issues

### Families and Children

- Think in terms of family supports, not services. Promote family involvement.
- Consider a voucher system. Retain and develop an "infrastructure" of services which are available for purchase under a voucher system.
- Recognize that many DD individuals and their families need a continuum of long-term support. A safety net is needed.
- Consider providing respite care through the state institutions.

---

## Family issues

- Provide training to families.
- Recognize that families face difficult problems in accessing a fragmented service delivery system involving many agencies. Clarify the role of case management.
- Consider giving the natural or adoptive family the same supports given to a foster family, e.g., Medicaid and SSI.

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# PROGRAM REVIEW

## Chapter Three

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**T**his chapter discusses aspects of specialized developmental disability programs in Washington. The topics to be addressed are:

1. The ICF/MR program, which includes state institutions and contracted nursing facilities and group homes.
2. Community services, which includes a broad array of programs and services.
3. Limitations of the available data, especially on community services.
4. Problems in comparing costs of institutions and community placements.

The state budgets since 1989 have included significant funding to decrease the population of the state institutions and expand community residential placements and other community programs. Between December 1989 and December 1991, approximately 415 residents of ICF/MR facilities were transferred to community residential placements. This figure includes almost an equal number of former residents of the state institutions and of the contracted ICF/MR facilities.

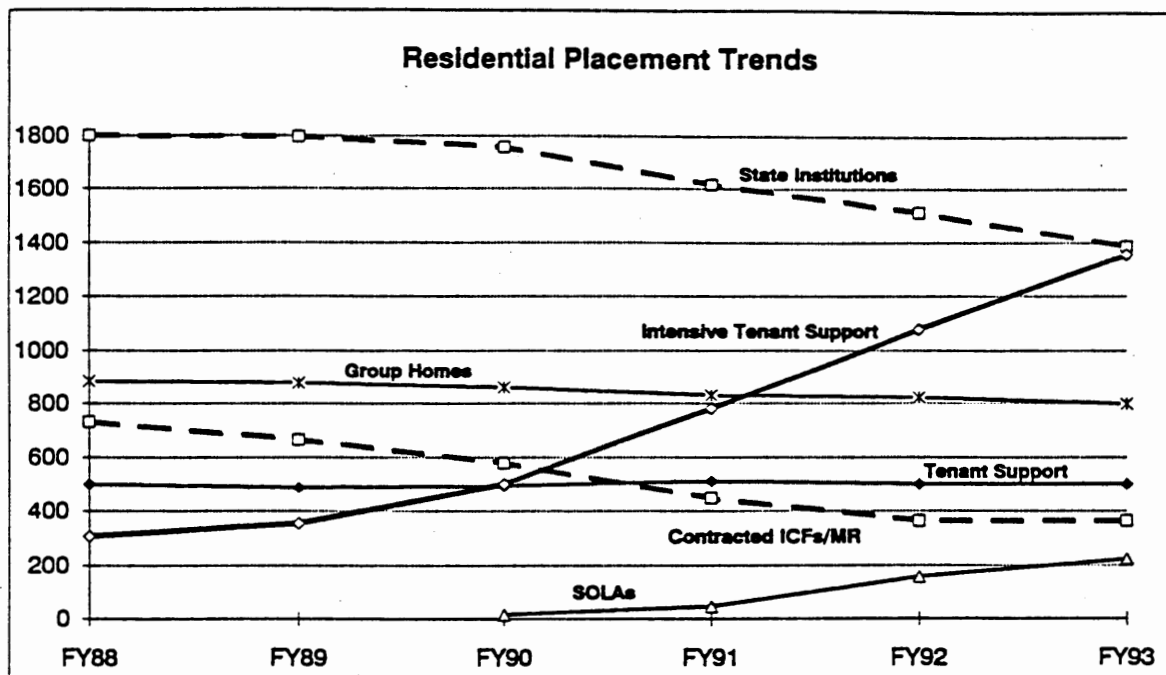
The graph on the next page shows the overall picture on trends in the various types of residential placements. The supporting data appear beneath the graph. The data for fiscal years 1992 and 1993 are based on the initial allotments for the 1991-93 biennium and thus exclude the budget reductions that took effect on December 1, 1991, and possible budget changes in 1992.

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### Overview

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### Recent transfers to community placements

**Exhibit 3.a.****Exhibit 3.b.**

## Residential Placements

	FY88	FY89	FY90	FY91	FY92	FY93
State institutions (RHC)	1799	1795	1757	1616	1511	1386
Contracted ICF/MR	731	665	578	447	364	364
Community Placement **	1694	1720	1869	2168	2556	2877

**\*\* Includes Group Homes, Tenant Support, Intensive Tenant Support, and SOLA (see below).**

## Community Placement Breakout

	FY88	FY89	FY90	FY91	FY92	FY93
Group Homes	886	878	861	831	822	799
Tenant Support	500	487	493	510	500	500
Intensive Tenant Support	308	355	500	781	1078	1355
SOLA (State Operated Living Arrangement)			15	46	156	223
TOTAL	1694	1720	1869	2168	2556	2877

**SOURCE:** Data furnished by DSHS, November 1991.

## ICF/MR PROGRAM

Almost half of DD funding this biennium is devoted to residences that participate in the Medicaid ICF/MR program (Intermediate Care Facilities for the Mentally Retarded).

The program currently includes five of the six state DD institutions and 24 contracted facilities (five skilled nursing facilities, ranging from 17 to 80 beds, and 19 small group homes, ranging from 5 to 10 beds.) The state institutions and other ICF/MR facilities provide comprehensive care for the residents, including treatment, vocational training, habilitative programs, and medical and dental care.

The ICF/MR facilities are supported by federal-state Medicaid funding. The federal share of Medicaid benefit costs in Washington is 54.98 percent during this fiscal year (federal FY 1992).<sup>1</sup>

Federal funding is contingent on annual certification that the institution or contracted facility meets the ICF/MR program standards, including the "active treatment" standard that in recent years has led to audit exceptions and at least temporary loss of federal funding. In response to certification problems, the institutions have made major changes such as the following:

- Institutional populations have been decreased through transfers to community placements.
- Institutional employees have received training in the ICF/MR program standards.
- The number of institutional staff has been increased, both in relation to the fewer residents and on an absolute basis.

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What is  
ICF/MR?

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Certification  
problems

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<sup>1</sup> The federal match applies to services and other allowable charges that qualify for federal financial participation under the Medicaid ICF/MR program. Because of the different "mix" of services and other allowable charges, the actual federal share varies between ICF/MR facilities and can be considerably higher or lower than the general 54.98 percent rate. Also, the matching rate changes every year. These factors must be taken into consideration when computing the state's share of costs for the institutions and other ICF/MR facilities.

Five of the six state institutions are currently certified as ICF/MR facilities. Interlake School lost ICF/MR certification in 1991, and the status of federal funding for Interlake is unclear. The 1991-93 biennial budget directed DSHS to operate the institution with state-only funding. The initial allotment data (based on the appropriations) indicate that Interlake has no federal funding. However, according to authoritative testimony at legislative hearings, Interlake has been converted to a Medicaid nursing facility and continues to receive federal matching funds on that basis.

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## Trends

The charts on the next page show relevant data from the last three biennia on the state institutions and contracted ICF/MR facilities:

- Exhibit 4.a. compares the number of facilities, residents, and dollars. The dollars are biennial figures.
- Exhibit 4.b. compares average annual dollars per resident.
- Exhibit 4.c. compares average annual staffing ratios at the state institutions, which are a main "driver" of institutional costs. The staff figures used to compute the ratios include all staff positions, not just direct care staff.

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## Washington and other states

Washington is reducing its reliance on the state institutions and other ICF/MR placements because of certification difficulties and rising costs. We examined data from various sources to compare Washington with other states in terms of utilization of institutions and total ICF/MR placements. By most available measures Washington ranks near the middle of the states.

First, we reviewed data on the number of residents in state institutions for the developmentally disabled. The latest available data refer to 1989.<sup>2</sup> The national mean was 35.7 residents in state DD institutions for every 100,000 persons in the total population. Washington had 36.9 residents of state institutions per 100,000 state population, ranking 21st highest among the states. The range was from about 91 state institution residents in Wyoming per 100,000 population to under 10 in Arizona.

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<sup>2</sup> The data are reported in project report 33 by the Center for Residential and Community Services, Institute on Community Integration, University of Minnesota, entitled Persons with Mental Retardation and Related Conditions in State-Operated Residential Facilities: Year Ending June 30, 1989. The data are collected by an annual survey of state DD agencies.



Exhibit 4.a.

ICF/MR Program since 1987: Biennial Comparisons									
	1987 - 89 Biennium			1989-91 Biennium			1991 - 93 Biennium		
	<u>Facilities</u>	<u>Average Residents</u>	<u>Expenditures (In Millions)</u>	<u>Facilities</u>	<u>Average Residents</u>	<u>Expenditures (In Millions)</u>	<u>Facilities</u>	<u>Average Residents</u>	<u>Budget (In Millions)</u>
State Institutions (RHC)**	6	1797	\$207.6	6	1687	\$262.0	6	1449	\$295.1
Contracted ICFs/MR	33	698	\$37.4	?	513	\$39.2	24	364	\$36.9
TOTAL	39	2495	\$245.0		2199	\$301.2	30	1813	\$332.0

\*\* The RHC figures include Interlake School, which lost ICF/MR certification in 1991.  
Source: Compiled by LBC staff from data furnished by DSHS, November 1991.

Exhibit 4.b.

Annual Dollars per Resident (From Main Budget Units Only: Excludes Other Costs)				
	<u>1987-89 Biennium</u>	<u>1989-91 Biennium</u>	<u>1991-93 Biennium</u>	<u>Cumulative Percent Change since 1987-89</u>
State Institutions (RHC)	\$57,753	\$77,677	\$101,858	76%
Contracted ICFs/MR	\$26,777	\$38,250	\$50,710	89%
TOTAL	\$49,088	\$68,488	\$91,560	87%

Source: Computed from Exhibit 4.a. data.

Exhibit 4.c.

Staff to Client Ratios: State Institutions			
	<u>1987-89</u>	<u>1989-91</u>	<u>1991-93</u>
Fircrest	1.83	2.17	2.49
Interlake	1.89	2.12	2.18
Rainier	1.80	1.97	2.27
Lakeland	1.74	2.00	2.23
Yakima	1.78	1.93	2.59
FHMC	1.94	1.97	2.14
Total	1.81	2.05	2.34

Source: Computed from DSHS data, November 1991.

Second, we reviewed data on state utilization of the ICF/MR program.<sup>3</sup> This is a broader measure than the above, since it includes both state institutions that are ICF/MR certified and contracted ICF/MR facilities. As of 1990, which is the latest available data, Washington had 49 residents in ICF/MR facilities per 100,000 state population, ranking 29th highest among the states.

We reviewed ICF/MR utilization data over time. It is difficult to compare the trend in Washington with that in other states because the data do not distinguish between ICF/MR residents in state institutions and contracted facilities. Nationally, the total number of ICF/MR recipients increased between 1984 and 1990 by a cumulative total of four percent, while the number decreased in Washington by 16 percent (from 2,844 to 2,384). The contrast is probably due to different patterns in developing small ICF/MR facilities with 15 or fewer residents, which are more prominent in other states. Nationally, the population in large state institutions has declined steadily over the last twenty years, as in Washington.

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## ICF/MR cost increases

We also analyzed ICF/MR expenditure data by state. ICF/MR costs have increased more in Washington than in other states. In 1984, the average ICF/MR cost per recipient in Washington was about \$31,000, which was close to the national average of about \$30,000. In 1990, the Washington figure had risen to almost \$61,000, versus the national average of about \$50,000. Washington's state ranking in cost per ICF/MR recipient rose from 16th highest in 1984 to 11th highest in 1990.

## Community Services

Community Services is a major category of the Division of Developmental Disabilities budget. It includes funding for various specialized services for people with DD who live outside the state institutions. The purpose is to provide a range of options and services to help people with DD to remain in the community. Some of the services funded in this broad category are:

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<sup>3</sup> The data were provided by SysMetrics/McGraw-Hill, Lexington, Massachusetts, which analyzes information for the federal Administration on Developmental Disabilities. The data include ICF/MR recipients and expenditures by state (program 2082 data).

- All contracted residential programs and services.
- State-operated residences (SOLAs).
- Funding for employment, day, and other programs through the counties.
- At-home family support services, such as respite care and therapy.
- Case management and other services by the Division of Developmental Disabilities Field Services offices.
- Consulting, technical assistance, and other services.

In reviewing data about other states, we found that DD community services funding in Washington ranked low as of 1988, the latest year for which data are available. At the time Washington ranked 39th among the states in terms of the proportion of the DD budget devoted to community services.<sup>4</sup>

Community services funding in Washington has grown significantly since 1988. Biennial funding rose from \$143.9 million in 1987-89 to \$336.9 million during the current 1991-93 biennium, an increase of 134 percent.

The graph on page 20 shows the trend in the major types of contracted residential placements, including Intensive Tenant Support, Tenant Support, and Group Homes. The increase in Intensive Tenant Support is intended to accommodate transfers from the state institutions and contracted ICFs/MR.

## DATA PROBLEMS

Despite cooperation and responsiveness from DSHS personnel, the LBC staff encountered major difficulties in collecting and analyzing DD fiscal and program data, especially in the Community Services portion of the budget. Much information is available, but it is complicated by ambiguous terms, conflicts with other data, and other problems. Some data categories are composites that must be

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Low percent  
of budget  
devoted to  
community  
services

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<sup>4</sup> Computed from data in Braddock, Hemp, et al., The State of the States in Developmental Disabilities (1990). More recent data (beyond 1988) from various states may be available in 1992.

broken down to get basic information such as the number of clients in each type of community residential placement. Another problem is that funding used for community residential placements is spread over various budget units, which makes it difficult to obtain even rough estimates of the costs of each type of community placement.

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### Why the data are confusing and unhelpful

The data problems appear to involve factors such as the following:

- An apparent lack of consistent and mutually exclusive definitions for DD program elements and residential alternatives.
- The impact of federal data and format requirements, which tend to be inconsistent with state usage.
- The lack of a central database on developmental disabilities and the presence of various reporting systems with somewhat different data categories.
- Data categories for budget, accounting, and workload figures are fragmented and may not provide clear summary information that is useful for policy making.

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### Planners should address data problems

An in-depth review of data needs, sources, and systems was beyond the scope of this study. We believe that the problems are significant and result in confusion among those trying to understand the DD system and chart future policy directions. In our opinion, the data problems should be addressed by DSHS in its long-range planning process for developmental disabilities.

## COST COMPARISONS

A major topic for later work is the cost of the various types of community residential placements compared to the state institutions. We intend to report fully on cost issues in briefings during 1992 and in the report scheduled for September 1992. The following section is an introduction to the subject.

Exhibit 4.b. on page 18 shows annual costs per resident at the state institutions, as calculated from the Division of Developmental Disabilities budget units for the state institutions. The 1987-89 and 1989-91 figures are "actuals," and the 1991-93 figures are based on the initial budget allotments for this biennium. We call these

figures "base costs." They exclude capital costs, field services, client participation, and various other additional costs funded from other sources. However, the additional costs are relatively minor. Based on detailed data collected by the LBC staff in early 1991, we believe that the base costs of the state institutions amount to about 90 percent of the total costs.

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**"Base costs"  
of state  
institutions**

For this report we had hoped to obtain figures on the "base costs" of community residential placements that were roughly comparable to the institutional base costs referenced above. We were unable to complete that task because of limited time and the inherent complexity of identifying the many costs associated with community residential placements.

There is a widespread tendency in the DD field to compare institutional costs solely with the contract rates paid to a community residential provider. Such comparisons are misleading for at least three reasons:

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**Misleading  
comparisons**

1. Many services included in the institutional costs are not included in the contract rates for community residential placements. For example, the institutions include medical care and vocational or day activities that in a community residential placement are purchased separately at additional cost.
2. In addition to funds for contracted services to support persons transferred from institutions to community placements, the DD budget includes funds for startup costs, rent subsidies, furniture, equipment, clothing, and other items.
3. There are many costs funded by sources outside the DD budget, such as federal income support programs. These costs are increased significantly when a person is transferred from a state institution to a community residential placement.

Another common approach is to assume that overall costs can be reduced simply by transferring individuals from an institution to "lower cost" community settings. This assumption may also be misleading. If the number of institutional residents is reduced by a limited "downsizing" policy, there are few opportunities for institutional cost savings. The total institutional costs remain

about the same.<sup>5</sup> On a per capita basis the institutional costs are increased because they are spread over a smaller population base. However, the costs of the contracted community services needed to support the former institutional residents are new additional costs.

Thus, if small portions of the institutional population are transferred to contracted residential care, the total institutional costs would be little (if any) reduced, while the new cost of the contracted residential services would be added to state expenses. The net effect would be higher overall expenditures.

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<sup>5</sup> Many institutional costs are fixed or semi-fixed, that is, they do not vary in relation to the size of the resident population. These costs are particularly unresponsive to small changes in the number of residents. However, large population reductions might achieve major cost savings through closure of entire living units.

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# SERVICES TO FAMILIES AND WAIVERS

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## Chapter Four

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**T**his chapter discusses other specialized services or programs for people with developmental disabilities. The topics are (1) support to families with a DD child or adult living at home, and (2) the Medicaid "Home and Community Based" waiver program, which is a major means of obtaining federal Medicaid funding for clients who live at home or in a community residential placement. These topics include consideration of the federal funding for DD programs.

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### Overview

## SERVICES TO FAMILIES

### Introduction

Most people with developmental disabilities live at home with their families, relatives, or guardians, or in their own homes. They are generally regarded as the least-served or most under-served population in the DD community.

Some services are provided through the Family Support category of DD funding. This category includes respite care, attendant care, therapeutic services, and other in-home support for families with a DD member. The most common service is respite care. According to DSHS, at least 90 percent of the Family Support clients are children.

Biennial funding for Family Support is about \$13.2 million to serve an estimated 1,600 families a year. This is an average of some \$4,100 per year per family. The average assumes that a family receives continuing service each month, which is frequently not the

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Most people  
with DD live  
at home

case. Despite this limitation in the data, it is clear that Family Support is less costly than comparable services in institutions or in community residential placements.

Because of budget limitations, Family Support services were cut back in September 1991. Service levels will be maintained for families currently receiving services, but no new services will be authorized until further notice. As of December 1991, the Division of Developmental Disabilities is revising Family Support priority categories and revising payment rates in order to improve administration and budgetary control.

Besides Family Support, other programs funded by the Division of Developmental Disabilities provide services that help families to maintain a disabled member at home. Examples include case management, employment and day programs, and early intervention.

### The Equity Issue

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#### Disparity between funding and clients

If a family places a disabled member in a state institution or in a community residential program, the state (often with federal matching funds) pays virtually all of the costs of care. However, if a family cares for a disabled member at home, relatively few services are available to them from programs funded by the Division of Developmental Disabilities. This disparity is sometimes known as the "equity issue."

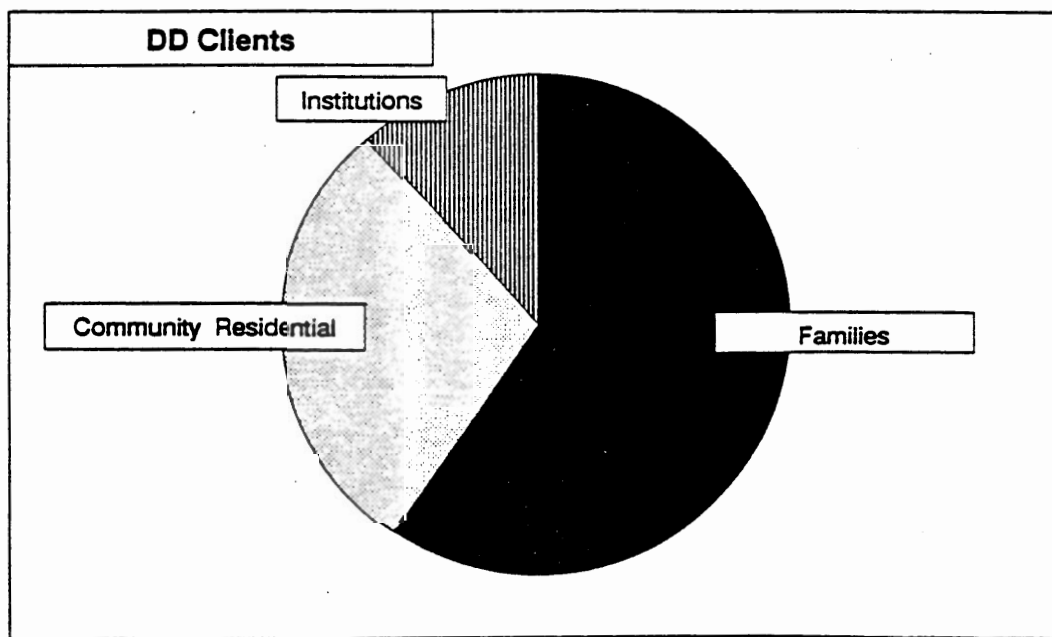
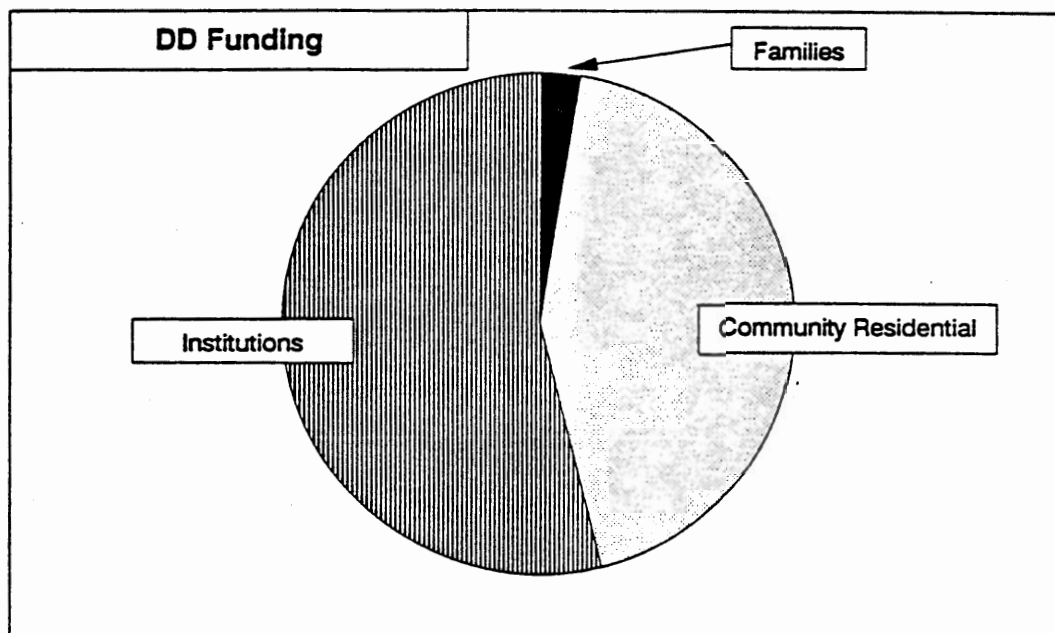
Exhibit 5 on the next page compares the estimated distribution of funding and clients in the state institutions, community residential programs of all kinds, and individuals living at home. As can be seen, there is a large disparity between the amount of funding devoted to each type of setting and the number of clients in that category.

The data must be viewed with caution because the service needs of each population are not clearly known. However, "waiting lists" were compiled by case managers in 1990. They indicate that 1,431 eligible people were in need of a residential placement and that 1,954 were waiting for services provided through the counties, such as employment or day programs.



## Exhibit 5

**Distribution of Funding and Clients by Residence Type**  
**Division of Developmental Disabilities**  
**1991-93 Budget / September 1991 Client Counts**



Source: Prepared by LBC Staff from DSHS Data

## Why the Equity Issue Persists

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### The funding system favors services in out-of-home placements

Many observers believe for both humanitarian and fiscal reasons that state policy should encourage families to care for a developmentally disabled person at home rather than relying on out-of-home placements. We searched for reasons why relatively little funding is available for this purpose. We found five points that appear to contribute significantly to the persistence of the "equity issue."

1. It is exceptionally difficult to reduce or discontinue services to those already in state institutions or community residential placements. Many such individuals have no other place to go. Given limited funding, those already in state-supported care receive the highest priority.
2. Federal regulations require high standards of care within state institutions, under threat of losing Medicaid certification and large amounts of federal funding. This factor makes it difficult to impose budgetary cutbacks in the institutional segment of the DD budget.

Because of these constraints, "non-residential community services" are the most significant items within the DD budget available for reducing or avoiding increases in state expenditures. The "non-residential community services" refer to all DD specialized services for families with a disabled member at home, including Family Support, employment and day programs, early intervention, and case management.

3. Under the existing "institutionally-oriented" Medicaid criteria, relatively little federal funding is available for services to support families with a developmentally disabled child or adult living at home. State budget reductions (such as those currently in progress) tend to impact family-oriented services first.

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### Budget cuts

We tested these three points against the proposed budget cutbacks scheduled for implementation on December 1, 1991. Using data supplied by DSHS, we compared the reductions in each DD budget unit with the ratio of federal matching funds applicable to that unit. We also compared the reductions in institutional and other residential programs with those in the non-residential programs.

The results are shown in Exhibit 6 below. We found that (a) the largest cuts were made to programs receiving little or no federal funding, and (b) the smallest cuts occurred in the institutional and other residential programs.

Exhibit 6

BUDGET REDUCTIONS — DECEMBER 1, 1991 DSHS DEVELOPMENTAL DISABILITIES PROGRAMS DIVISION PROPOSALS — ALL FUNDS			
<u>PROGRAM</u>	<u>ORIGINAL ALLOTMENT</u>	<u>12/1/91 % CUTS</u>	<u>FEDERAL % MATCH</u>
<b>COMMUNITY SERVICES</b>			
Residential Programs	\$203,414	1.3%	45.0%
Family Support	\$13,292	4.6%	10.0%
Professional Services	\$3,011		25.0%
Employment & Day Programs	\$64,250	2.1%	6.0%
Technical assistance	\$1,012	19.8%	21.0%
Field Services	\$23,587	8.9%	23.0%
SOLAS	\$27,494	0.5%	52.0%
Other Community Programs	\$840	1.5%	0.0%
<b>INSTITUTIONS</b>	<b>\$296,217</b>	<b>1.2%</b>	<b>49.8%</b>
<b>HEADQUARTERS SUPPORT</b>	<b>\$7,022</b>	<b>3.6%</b>	<b>16.0%</b>
<b>GRAND TOTAL</b>	<b>\$640,142</b>	<b>1.8%</b>	<b>42.0%</b>
<div>Items with low federal matching funds generally received largest proposed budget cuts.</div> <div>Residential and Institutional programs received the smallest cuts.</div>			

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## DSHS interpretation of budget language

4. Language in the 1991 budget bill prohibits DSHS from initiating "any services that will require expenditure of state general fund moneys unless specifically authorized . . . or unless the services were provided on March 1, 1991." Despite some other language that might be interpreted as exempting developmental disabilities, DSHS fiscal staff indicate that the net impact of the budget language is to discourage the agency from attempting to reach unserved or underserved individuals.
5. Closely related to the previous item, the budget act language requires that any additional federal money received by DSHS shall cause an equal amount of appropriated state general fund money to lapse.

This fifth point may reduce the incentive for DSHS to pursue federal funding that might be used for DD clients living at home (mostly through the "waivers" discussed in the following section). Additional work by case managers and other DSHS staff is required to authorize and maintain waiver services for new families. Moreover, according to DSHS staff, there is no overall financial gain for DD programs because the additional federal funding is offset by reduced state general fund money.

## MEDICAID WAIVERS

### Introduction

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## What are waivers?

The Medicaid ICF/MR program has historically been oriented to funding institutional care. Federal legislation enacted in 1981 permits states to apply for waivers from various Medicaid regulations and use Medicaid funding for "home and community based services." The waiver funds may be used to support developmentally disabled persons eligible for institutional care but for whom it is more cost-effective to provide services at home or in a community residential placement.

The home and community based waivers can be used to increase the kinds of services that qualify for Medicaid matching funds. The waiver can provide funding for the following additional services if not covered in the state Medicaid plan:

- Case management
- Homemaker services
- Home health aide services
- Personal care (broadly-defined physician-prescribed services)
- Habilitation services (broadly-defined health & social services)
- Adult day health services
- Respite care
- Other services (broadly-defined)

Home and community based waivers are the only available vehicle for diverting institution-oriented Medicaid ICF/MR funding to community programs, both residential and non-residential. The waiver services must be specifically requested in the state application to federal authorities. The application process for waivers is complex and lengthy.

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Home and  
community  
based waivers

Waiver services are limited to persons who qualify for institutional care (certified by medical personnel). Thus, a DD client must meet the criteria for "institutionalization" in order to qualify for the alternative services authorized by the home and community based waiver. While a cost saving for individual clients is not required, the state must initially claim and annually prove an aggregate cost savings in accordance with a federally-prescribed formula. Interestingly, the formula considers only Medicaid costs and excludes costs incurred by other federal programs.

### Washington State Waivers

Washington has three Medicaid waiver programs to serve people with developmental disabilities, as described below.

1. The "CAP" Waiver. This is the main home and community based waiver and is known by its state name, Community Alternatives Program (CAP). For 1991-92 this waiver authorizes DSHS to receive up to \$34.6 million in federal waiver funds. After state matching funds are added, this waiver could provide up to \$63 million per year for DD services. If a similar amount is authorized for 1992-93, the waiver would represent about 20 percent of the DD budget. The current waiver expires in April 1992, and DSHS will reapply.

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"CAP" waiver

In 1991-92 the CAP waiver authorizes services for up to 2,275 persons. According to DSHS, 1,726 clients were being served under the waiver as of late 1991. The residence types are as follows:

- 1,498 live in community residential placements (intensive tenant support, group homes, and adult family homes).
- 160 live in the home of parents, relatives, or guardians.
- 52 live in their own homes.
- 16 live in other settings.

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## Unfilled waiver slots

During the current waiver year (April 1991-April 1992), a cumulative total of 1,813 persons have been served under the CAP waiver as of mid-December 1991, out of an authorized limit of 2,275 persons. This means that 462 CAP waiver slots are unfilled, or 20 percent of the authorized limit.<sup>1</sup>

2. The OBRA waiver. This waiver is based on federal legislation of 1987 and is known by its state name, "Outward Bound Residential Alternatives." The legislation requires states to move developmentally disabled nursing home residents who do not require 24-hour care to less restrictive settings. (There are exceptions; not all such persons must be moved.)

The OBRA waiver authorizes community living services for up to 164 nursing home discharges in 1991 and 270 in 1992 at a cost of \$4.7 million and \$8.7 million respectively, representing about 2 percent of the DD budget. About 59 clients are currently being served under this waiver, of which 41 are living in intensive tenant support. None of them live with parents or relatives.

3. The Medically Intensive Waiver. This waiver provides funding to serve at home up to 50 medically fragile children who would otherwise need more costly institutional care. Ten clients are currently being served. All live with their parents.

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<sup>1</sup> See Appendix 2 for more information on this topic.

## Waiver Trends, Comparisons, and Opportunities

We discussed the waivers with various authorities and reviewed some of the extensive literature on the topic, with attention to Washington's utilization of the waivers compared with other states. We found that this state's use of the waivers to expand community residential placements is cited in the national literature as a commendable example. We also found some opportunities for improvements. The following comments refer to the main waiver (CAP).

Washington had one of the first home and community based waiver programs (starting in 1983), but it appears to have fallen behind other states in utilizing the waiver to the fullest extent. As of June 1990, according to survey data from the University of Minnesota, Washington ranked 18th in the nation (out of 44 states with waiver programs at the time) in waiver recipients per unit of state population.

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Washington is  
losing national  
waiver  
leadership

We found that waiver programs in some other states are said to be increasing the emphasis on services to families with DD members living at home through the expansion of requested waiver services and through innovative application of the waiver program. This point is stressed in a recent report by the National Association of State Mental Retardation Program Directors:

*"... first-generation HCB waiver programs ... are being transformed into 'second-generation' programs that place greater emphasis on furnishing supports to individuals living in their own homes or with their families." <sup>2</sup>*

Supported employment for former institutional residents is an authorized waiver service in over half the states with waiver programs. Necessary home modifications qualify as an authorized service under the waiver in a growing number of states. In addition, some states are reported to use the waiver to cover homemaker-type services, various kinds of day programming, home companions, and (limited) transportation.

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<sup>2</sup> NASMRPD, The HCB Waiver Program and Services for People with Developmental Disabilities: An Update (January 1991).

So far as we could determine, few of the above services are provided under the Washington CAP waiver. Some of them are funded from other sources. (After reviewing this report, DSHS staff indicate they plan to request additional services under the CAP waiver renewal due in April 1992.)

### Waiver services to people living at home

In light of the "equity issue" discussed previously, we explored the extent to which waiver funding is used to provide services to families who are caring for a disabled person at home. We compared the percentage of Washington "waiver recipients" living at home with comparable figures from 20 other states, as reported in survey data. The results are shown in Exhibit 7 below. About nine percent of the waiver recipients in Washington live with families or relatives, compared with nearly 14 percent in the other states.

While a growing number of Family Support clients in Washington are supported by the CAP waiver, DSHS staff indicate that under an informal internal policy the waiver is used for Family Support only when services of more than \$500 a month are required. The purpose is to save the waiver "slots" for higher-cost clients in need of community residential placements.

Exhibit 7

#### HCBS WAIVER RECIPIENTS BY TYPE OF RESIDENCE

<u>Residence Type</u>	<u>Washington*</u>		<u>20 Surveyed States**</u>	
	<u>Residents</u>	<u>% of Total</u>	<u>Residents</u>	<u>% of Total</u>
Parent/Relative/Guardian's Home	160	9.0%	2071	13.9%
Own Home With Support Services	55	3.1%	549	3.7%
Staffed Residence (Paid Provider)	1570	88.0%	12293	82.4%
Total	1785		14913	

\*Source: DSHS. Includes CAP and OBRA Waivers.

\*\*Source: Center for Residential and Community Services  
University of Minnesota, Report #34, June 1991



## Conclusions

The Washington Medicaid waivers for people with developmental disabilities emphasize community residential placements. It appears that the CAP waiver has been used primarily to support individuals already in state care, such as institution residents who move to a community residential placement.

The CAP waiver is used least to provide in-home and other support services to families caring for a disabled person at home. This results from the limitations of the current waiver, which excludes many services that could be offered to the at-home population, and from the general low priority given to at-home services by the current service delivery system.

It appears that services desired by families caring for a disabled person at home could be expanded and the number of families served by the DD system increased through aggressive pursuit of waiver modifications and innovations. However, additional state matching funds would be required.

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Opportunity  
to expand  
waivers

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# **INNOVATIVE APPROACHES IN OTHER STATES**

## **Chapter Five**

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**W**e collected information from three states reputed to have “progressive” DD systems or at least innovative programs worth exploring, as opposed to being “representative” or “typical” states. The states are New Hampshire, Michigan, and Wisconsin. The material is incomplete because of the short time available for research. In our work scheduled for 1992, we plan to develop some of the following information and to explore innovative approaches in other states.

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### **Overview**

Unlike Washington’s system of state DD services, the three states discussed below all have decentralized DD systems based on counties or regional authorities. We did not know this when the states were selected for study. The choice of states should not be interpreted as advocacy for a decentralized system. The research on New Hampshire was conducted by the LBC staff. The research on Michigan and Wisconsin was done by Jonnel Anderson, Senior Research Analyst on the staff of the Senate Republican Caucus.

### **NEW HAMPSHIRE: A COMMUNITY- BASED SYSTEM WITHOUT INSTITUTIONS**

New Hampshire has recently attracted national attention by closing its only state DD institution and providing services to all recipients in family and community settings. It is the only state in which the DD system is entirely family or community-based.

## Decentralized System

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### The New Hampshire system

Exhibit 8 on the next page shows the DD system in New Hampshire. The system is based on 12 regional Area Agencies. They are the point of entry into the system and provide all specialized DD services, either directly or by contract. Roughly 90 percent of the funds appropriated to the New Hampshire state DD agency are contracted to the Area Agencies.

The New Hampshire chart may be compared to the sketch of the Washington DD system on page 6 above. Specialized DD services in Washington require extensive coordination among staff from various organizations, such as the Division of Developmental Disabilities Field Services case manager, the residential contractor, county staff, and a county contractor for employment or day programs. In New Hampshire's decentralized system, coordination is still required but fewer organizations appear to be involved. The state DD agency does not provide direct client services.

The Area Agencies in New Hampshire are responsible for eligibility determination, service authorization, and case management, which are provided in Washington by state employees. Case management in New Hampshire is provided directly by some Area Agencies. In other regions this function is performed by a contracted residential provider, who is paid an "add on" rate for case management.

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### Family support

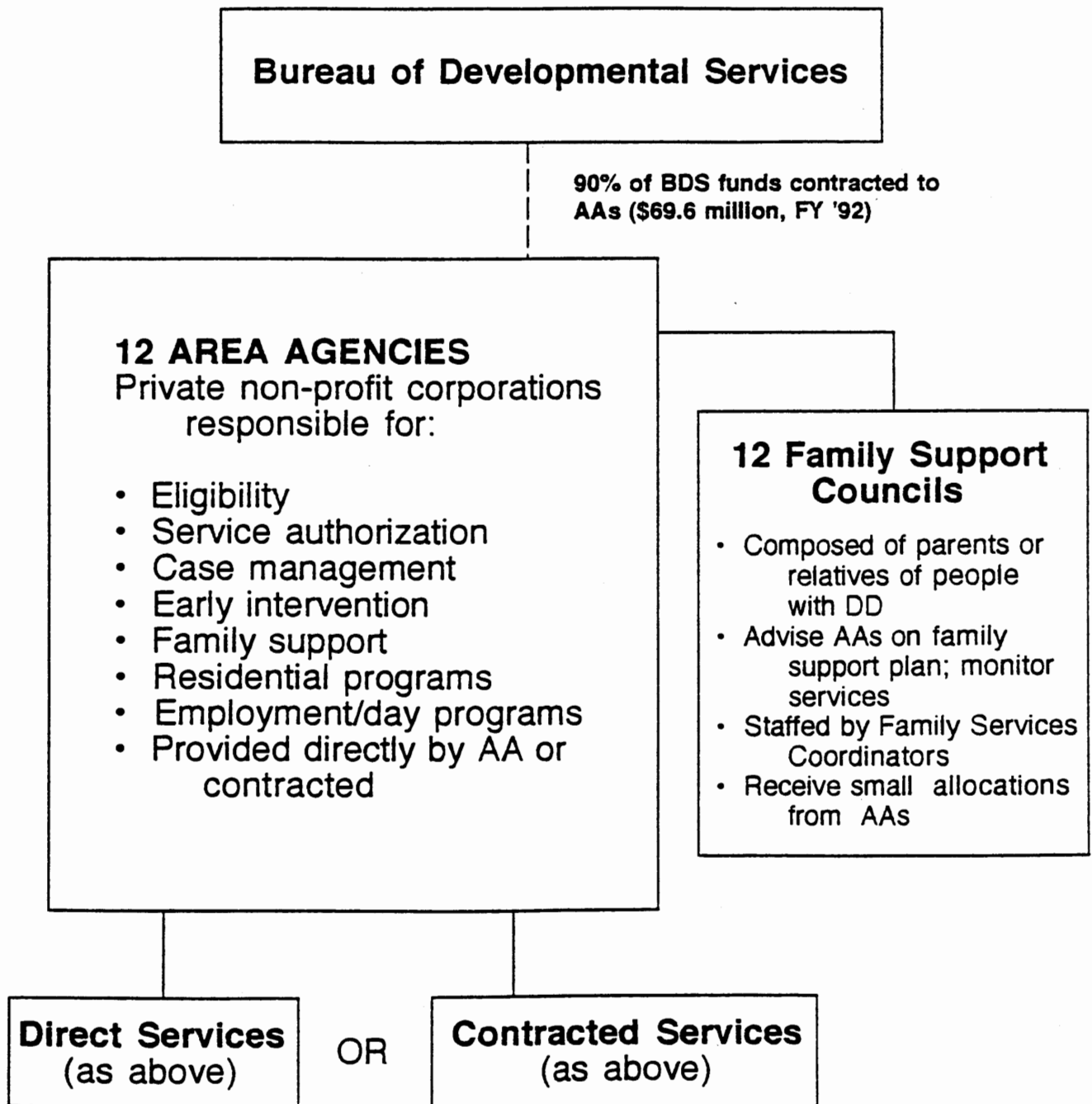
Family support services in New Hampshire are provided by the Area Agencies, either directly or by contract. Family support services are relatively well funded (about 6 percent of the New Hampshire DD budget, versus about 2.1 percent in Washington). The funding level is a reflection of 1989 state legislation which declared that it is "more efficient, cost effective, and humane" to care for people with DD at home as opposed to other settings. The 1989 legislation also created the 12 Family Support Councils shown in Exhibit 8.

Composed of family members of people with DD, the Family Support Councils are advisory bodies to the Area Agencies on family support issues. In "advising" on the regional family support plan, the councils in some cases are said to heavily influence or control how the Area Agency spends its family support resources. In addition, each council has small amounts of funding. Some councils

## Exhibit 8

# New Hampshire Developmental Disabilities System

N.H. Department of Health and Human Services  
Division of Mental Health



Source: LBC Staff

are said to provide parent-to-parent networking, information and referral services, various other functions bordering on case management, and even respite care. The role of the Family Support Councils in relation to the Area Agencies is not fully defined. In some cases the relations are strained.

Another notable aspect of the New Hampshire system is that the Area Agencies are private non-profit organizations. This status provides some flexibility not available to a governmental organization. For example, the Area Agencies are allowed to borrow money, which helps to solve "cash flow" problems when they are delays in receiving federal Medicaid funds.

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### Summary of New Hampshire characteristics

Thus New Hampshire's DD system appears to include decentralized decision making, regional variation, parent involvement, and perhaps a preference for flexible, non-governmental approaches. The literature emphasizes the importance of tapping into the "natural" support systems, such as neighbors and family members. According to a 1991 New Hampshire state publication describing the DD system (New Decade, New Decisions), "Paid staff will be provided only out of necessity, and then only to provide specific, critical supports not otherwise available."

### Funding

We analyzed the amount of funding available for DD specialized services in New Hampshire and Washington. We found that the two systems have roughly equal funding on a per capita basis. The New Hampshire appropriations for the 1991-93 biennium are some \$149 million, compared to \$640 million in Washington with its much larger state population. These amounts are equivalent to \$134.37 per state resident in New Hampshire and \$131.52 in Washington.

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### Community services funding

While the overall funding levels are similar, the amounts allocated to various types of DD services are very different. Exhibit 9 on the following page shows that community programs in New Hampshire have much higher funding than in Washington.

The fiscal data are generally consistent with other sources of information, such as the 1988 survey data reported by Braddock, Hemp, et al. in the most recent edition of The State of the States in Developmental Disabilities (1990). We analyzed the figures re-

ported there and converted them to rates per state resident. Compared to Washington, New Hampshire had 10 percent more community residential placements and double the rate of supported or competitive employment for people with DD. New Hampshire also had a 10 percent higher rate of sheltered employment placements.

## Exhibit 9

**New Hampshire and Washington DD Funding  
per State Resident, 1991-93 Biennium**

	<u>New Hampshire</u>	<u>Washington</u>
Community Residences	\$75.04	\$41.79
Employment and Day Programs	\$33.74	\$13.20
Family Support	\$8.33	\$2.73
State Institutions	None	\$60.63
All Other Combined	\$17.26	\$13.17
 Total Appropriations	 \$134.37	 \$131.52

**SOURCES:** New Hampshire Operating Budget, Chapter 312, Laws of 1991, June 26, 1991, pages 292-93, line item appropriations to Bureau of Developmental Services. Initial allotments to Washington Division of Developmental Disabilities, July 1991.

**NOTE:** The New Hampshire figures should be a little higher than shown in the chart, since they exclude about \$5 million in funding from other sources. The Washington figures should be a little lower, since they are based on the initial biennial allotments and ignore the budget cuts implemented on December 1, 1991, and possible reductions in 1992.

## The Trend from Institutional to Community Services

In January 1991 New Hampshire closed its one state DD institution, Laconia, by transferring the remaining residents to community placements. When downsizing began in the 1970s, the institution had 1,200 residents. Downsizing was prompted by legal action which forced the state to reduce the institution population in order to meet quality standards. In the early 1980s the state made a major financial commitment to building a community services system.

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### Key points about downsizing

We discussed downsizing with various sources in New Hampshire. Some key points are as follows:

- Transferred residents are supported by extensive use of the Medicaid Home and Community Based waiver (discussed in Chapter 4). As of June 1990, waiver recipients in New Hampshire included 74.1 persons per 100,000 state population, compared to only 27.7 in Washington.
- The transferred residents live in a variety of community-based or family-based residences. The types of residences used in New Hampshire do not seem to have close counterparts in Washington. Unlike Washington, New Hampshire has many small group homes with three or four residents. It does not emphasize so much the Intensive Tenant Support model, which is the preferred type of placement in Washington.
- The transferred residents and also other people with DD are said to receive necessary support services, such as medical care and employment or day programs. We have no way of verifying this general information at this time. However, the information is consistent with the fiscal and survey data reported on the previous page.
- According to state officials, parent opposition to downsizing was reduced by the clear state commitment to building a strong system of community residential placements and supports. Another significant factor was passage of the 1989 legislation which established the Family Support Councils and committed the state to supporting families who care for DD people in their homes.

- According to state officials, the union representing institutional employees came to accept downsizing. The state offered extensive retraining and job placement, which was aided by the strong New Hampshire economy in the late 1980s. Some institutional employees found other jobs, some became contract providers of residential services, and about 60 are still employed by the state but assigned to community residential programs.

## **MICHIGAN: FAMILY SUPPORT THROUGH CASH SUBSIDIES**

### **Introduction**

We selected Michigan for study mainly to explore that state's unique cash subsidy program for families of children with severe disabilities. The program is part of a county-based DD system with a strong commitment to community services. Roughly 80 percent of DD funding in Michigan is devoted to programs designed to serve individuals in community or family settings.

During the 1980s Michigan closed eight state institutions. Of the five institutions that remain open, two are scheduled to be closed in 1992 and the others by 1994. The institutional residents will be transferred to community residences. It is state policy that group homes and other kinds of community placements may have no more than six residents.

Michigan law provides that counties may assume responsibility for both DD and mental health services if they are "able and willing" to do so. Community Mental Health Boards are appointed by the elected county commissions. About 45 of Michigan's 55 Community Mental Health Boards have assumed authority for managing programs for the developmentally disabled. The state contracts with the boards for DD services. While certain core services are required, the state requirements are flexible and DD programs may have different emphases and priorities from county to county.

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### **The Michigan system**



## Cash Subsidy Program

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### Cash grants

Michigan's "Family Support Subsidy Act" has been in effect since 1984. It provides grants of \$222 a month to families with a severely disabled child under age 18 living at home. The child must be severely mentally retarded, severely multiply impaired, or autistic impaired, as defined by Michigan special education rules. The family income cannot exceed \$60,000 a year. The cash subsidy is not taxable and does not affect eligibility for other governmental benefits.

About 3,800 Michigan families receive the cash subsidy. Annual program funding is \$9.6 million. Every eligible family receives a subsidy. However, the amount of the subsidy depends on the appropriations level in relation to the number of eligible families. Limited funding has resulted in reduction of the subsidy from the original level of \$313 a month in 1984 to \$222 today.

The children are extremely disabled and require extensive care. The purpose of the subsidy is to defray the costs of care, thereby helping to keep families together and in some cases enabling children to return home from institutions or other out-of-home placements.

---

### Parental choice

The cash subsidy is intended to give parents maximum choice and control over services for the child. The subsidy may be spent at the parents' discretion for the child's special needs. This approach is in contrast to family support systems, as in Washington, which offer a limited menu of services. Another difference is that every eligible Michigan family regularly receives a cash subsidy, whereas the Washington family support program may not authorize services each month.

Michigan families who receive the cash subsidy may also receive family support services from the county. We were not able to develop information on the additional services, nor on what tends to happen when the child turns age 18 and is no longer eligible for the cash subsidy.

## **WISCONSIN: FAMILY SUPPORT SERVICES**

### **Introduction**

We studied family support services in Wisconsin. In collecting information on that topic, we found that Wisconsin has a decentralized service system with 72 counties responsible for DD and other social and health services. Each county has a Community Services Board appointed by the county executive. DD services differ greatly among the counties in terms of application procedures, service models, and funding priorities.

Wisconsin relies heavily on ICF/MR programs to serve people with developmental disabilities. There are about 1,600 residents in state-run DD institutions and about 4,000 in contracted ICFs/MR, many of which are large nursing homes. No state institutions have been closed. As of 1990 Wisconsin had 88 residents in ICF/MR institutions or contracted facilities, compared with 49 in Washington.

### **Family Support**

The Wisconsin Family Support Program discussed here is intended for children with developmental disabilities through age 21. The program goal is to keep families together by providing an extensive range of in-home support services. According to Wisconsin state officials, the program has resulted in an absolute decline in the number of DD children in out-of-home placements, while the number of other children in out-of-home placements has increased dramatically.

The program was started in 1983 and has been gradually expanded into a permanent program in all counties. The basic tenets of the program are: (1) Build on the family's strengths, (2) Work with parents as partners, (3) Offer a comprehensive array of services and access those offered through other service systems, and (4) Integrate family and community.

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### **The Wisconsin system**

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### **Family support**

The counties are required to provide a large number of specialized DD core services. These include necessary home and vehicle modifications, various kinds of therapy, special equipment and devices, and support services such as respite care, in-home services, home training, and transportation. The range of services is more extensive than in Washington, where the primary service is respite care. Another difference is that Wisconsin services are authorized on an annual basis with six-month reviews, compared to a monthly authorization in Washington.

---

## "Vouchers"

The Wisconsin program is similar to a "voucher system" in that the annual authorization level is similar to a bank account of services that may be drawn down over the year at the family's discretion (consistent with an approved plan). Parents are allowed to determine when the services are delivered and the types of services. The Wisconsin program, unlike Washington, also includes parental participation in the costs of services. The amount is normally three percent of family income after certain allowances are made for basic expenses.

Annual state funding is about \$3.2 million to serve about 2,000 families, or an average of \$1,600 per year. In addition, the counties are required to provide matching funds of at least nine percent of the state funding, and many counties are said to provide more. Information on total expenditures for family support services is not available. The state statute sets an upper limit of \$3,000 in services per child per year.

According to the statute, any family with a severely disabled child who wishes to care for the child at home is eligible for the family support program. To control costs, however, a rationing system is used. There are long waiting lists of eligible but unserved persons.

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# **AGENCY RESPONSE**

## **Appendix I**

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- **Department of Social and Health Services**

# AGENCY COMMENTS



STATE OF WASHINGTON  
DEPARTMENT OF SOCIAL AND HEALTH SERVICES

Olympia, Washington 98504-0095

January 7, 1992

Cheryle A. Broom  
Legislative Budget Committee  
506 East 16th Street, KD-11  
Olympia, WA 98504

Dear Ms. Broom:

Thank you again for the opportunity to review the Legislative Budget Committee's preliminary report on Residential Services for People with Developmental Disabilities. We have been providing comments and recommendations to LBC staff since the initial presentation of the report to the Committee on December 20th. Following yesterday's meeting with you and your staff to discuss additional corrections and clarifications to the report, we are satisfied that most of our comments have been incorporated into the proposed final document.

Given our previous communications, we will not submit additional recommendations prior to the LBC meeting on January 13th. Your careful consideration of our comments has been most appreciated, and we look forward in the months ahead to working with the legislature and with LBC staff on both the LBC study and the Developmental Disabilities' Long Range Plan.

Sincerely,

A handwritten signature in cursive script that reads "Linda Johnson".

Sue Ellison, Director *for*  
Division of Developmental Disabilities

cc: Richard J. Thompson

RECEIVED

JAN 7 1992

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# **MEDICAID WAIVERS: UNUSED CAPACITY**

## **Appendix 2**

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- **Letter to Sue Elliott, Director  
Division of Developmental Disabilities  
Department of Social and Health Services**
- **Letter to Cheryle Broom, Legislative Auditor  
Legislative Budget Committee**

The report shows (page 36) that as of December 1991 DSHS had not filled 20 percent of the Community Alternative Program slots authorized under this year's Medicaid waiver for home and community based services. In discussing the report on January 13, 1992, members of the Legislative Budget Committee asked questions on this topic. Specifically, they wanted to know whether the unused waiver authority was an isolated case or a recurring problem.

The following correspondence addresses that issue.

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von Reichbauer  
rairie Wojahn



REPRESENTATIVES

Joanne Brekke  
Gary Chandler  
Steve Fuhrman  
J. Bruce Holland  
Gary Locke  
Val Ogden  
Jean Silver, Asst. Secretary  
Helen Sommers, Vice Chair

STATE OF WASHINGTON

**Legislative Budget Committee**

SLATIVE AUDITOR

506 East 16th Street, ED-11 Olympia, Washington 98504

le A. Broom

(206) 786-5171  
SCAN 298-5171  
FAX 786-5180

January 16, 1992

Sue Elliott, Director  
Division of Developmental Disabilities  
Department of Social and Health Services  
P.O. Box 5310  
Olympia, WA 98504-5310

Dear Sue:

Representative Brekke and other LBC members have asked us to follow up on the questions asked at the committee meeting on January 13 about the Community Alternative Program Medicaid waiver.

The LBC report showed that about 462 waiver client slots, or 20 percent of the authorized limit, were unfilled as of December 1991. We wish to obtain more complete information about waiver authority and utilization, that is, the authorized number of waiver clients and dollars and the actual utilization in recent years.

The enclosed chart contains the partial information available to us from the materials collected by the LBC staff in late 1991. Please complete the chart going back to 1987-88, and back to 1983-84 if the figures are readily available. The information is needed by January 30.

If you have any questions about this request, please call Matt Temmel at 786-5171. Thank you.

Sincerely,

A handwritten signature in cursive script, appearing to read "Cheryle A. Broom".

Cheryle A. Broom  
Legislative Auditor

Enclosure

<b>"CAP" Waiver for Home and Community Based Services to People with Developmental Disabilities</b>						
	<b>Maximum Authorization</b>		<b>Actual Utilization</b>		<b>Unused Capacity</b>	
	<b>Clients</b>	<b>Dollars (Fed + State)</b>	<b>Clients</b>	<b>Dollars</b>	<b>Clients</b>	<b>Dollars</b>
1983-84						
1984-85						
1985-86						
1986-87						
1987-88	1,350	15,593,486				
1988-89	1,350	16,139,264				
1989-90	1,861	25,473,368	1,252	18,464,904	609	7,008,464
1990-91	2,184	52,647,504				
1991-92	2,275	62,997,025	1,813		462	
			(to Dec.)		(to Dec.)	
<b>SOURCES:</b>						
Maximum clients and dollars are from federal authorization letters to DSHS.						
Actual clients and dollars are from DSHS annual reports to HCFA ("372 reports").						





STATE OF WASHINGTON  
DEPARTMENT OF SOCIAL AND HEALTH SERVICES

Olympia, Washington 98504-0095

January 30, 1992

Cheryle A. Broom  
Legislative Auditor  
Legislative Budget Committee  
506 East 16th Street, KD-11  
Olympia, Washington 98504-5011

Dear Ms. Broom:

Enclosed is the information you requested concerning the number of individuals served on the Community Alternatives Program (CAP) Waiver, expenditures for their services, and the waiver capacity for each waiver year.

Since state dollars need to be appropriated to generate the federal funds for each waiver participant, we have utilized the following state funding: 1) dollars associated with individuals moving to the community from a publicly or privately operated intermediate care facility for the mentally retarded (ICF/MR), 2) any new dollars associated with serving unserved people living in the community and who are at risk of institutionalization, and 3) base level dollars for persons currently served and living in the community and who are at risk of institutionalization.

Historically the division has not used all of its approved waiver capacity. The reasons for this are as follows:

- In the past, the division has requested greater capacity than the state dollars appropriated, so that if additional state resources became available, we could easily expand our ability to obtain federal financial participation (FFP).
- In order to ensure those people with the greatest need receive services under the waiver, initial use of the waiver each year has focused on individuals for whom the division is spending the greatest amount of state funds (i.e., those currently being served in the community).
- Since more children than anticipated have been eligible for Title XIX personal care services, there has been reduced need to place children on the waiver.
- The current waiver capacity was based in part on accelerated downsizing (i.e., those moving to the community from an ICF/MR). This has been slowed down due to proposed budget reductions.

If you have any questions or would like additional information, please contact Linda Johnson at 753-1712.

Sincerely,

Sue Elliott, Director  
Division of Developmental Disabilities

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JAN 31 1992

Enclosure

cc: Linda Johnson

<b>"CAP" Waiver for Home and Community Based Services to People with Developmental Disabilities</b>						
	<b>Maximum Authorization *</b>		<b>Actual Utilization **</b>		<b>Unused Capacity</b>	
	<b>Clients</b>	<b>Dollars (Fed + State)</b>	<b>Clients</b>	<b>Dollars</b>	<b>Clients</b>	<b>Dollars</b>
1983-84	1,001	13,993,230	844	8,016,485	157	5,976,745
1984-85	1,001	14,413,027	933	11,660,470	68	2,752,551
1985-86	1,001	15,277,808	980	12,643,289	21	2,634,519
1986-87	1,001	15,277,808	905	5,325,354	96	9,952,454
1987-88	1,350	15,593,486	1,049	11,791,055	301	3,802,431
1988-89	1,350	16,139,264	1,047	14,496,792	303	1,642,472
1989-90	1,861	25,473,368	1,252	18,464,904	609	7,008,464
1990-91	2,184	52,647,504	1,557	31,590,659	627	21,056,845
1991-92	2,275	62,997,025	1,813	Not Avail.	462	
			(to Dec.)		(to Dec.)	
<b>SOURCES:</b>						
Maximum clients and dollars are from federal authorization letters to DSHS. *						
Actual clients and dollars are from DSHS annual reports to HCFA ("372 reports"). **						

\*Data on maximum authorized clients and dollars for 1983-84, 1984-85, 1985-86, and 1986-87 are from the approved waiver. The waiver was extended from 11/30/86-4/29/87 while HCFA was reviewing the department's request for waiver renewal. The client and dollar limits in effect during the prior period continued in effect during the waiver extension period.

\*\* Data on actual utilization for 1989-90 and 1990-91 are estimates. The final HCFA-372 Report for 1989-90 and the initial HCFA-372 Report for 1990-91 will be completed by February 20, 1992.

Note: As state dollars and resources allow, we will continue to add individuals to the waiver between now and April 29, 1992.



State of Washington  
Legislative Budget Committee

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# **Residential Services For People With Developmental Disabilities - Phase 3**

## **Report 93-1**

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January 14, 1993

**Members of  
The Legislative Budget Committee**

**SENATORS**

Scott Barr  
Al Bauer, Secretary  
Marcus Gaspard  
Bob Oke  
Nita Rinehart  
Peter von Reichbauer  
R. Lorraine Wojahn  
Vacancy

**REPRESENTATIVES**

Gary Chandler  
Steve Fuhrman  
Gary Locke  
Val Ogden  
Jean Silver, Asst. Secretary  
Helen Sommers, Vice Chair  
Vacancies (2)

Cheryle A. Broom, Legislative Auditor

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**Facts About  
The Joint Legislative Audit and Review Committee**

Established by Chapter 44.28 RCW, the Legislative Budget Committee provides oversight of state funded programs and activities. As a joint, bi-partisan legislative committee, membership consists of eight senators and eight representatives equally divided between the two major political parties.

Under the direction of the Legislative Auditor, committee staff conduct performance audits, program evaluations, sunset reviews, and other types of policy and fiscal studies. Study reports typically focus on the efficiency and effectiveness of agency operations, impact of state programs, and compliance with legislative intent. As appropriate, recommendations to correct identified problem areas are included. The Legislative Auditor also has responsibility for facilitating implementation of effective performance measurement throughout state government.

The LBC generally meets on a monthly basis during the interim between legislative sessions. It adopts study reports, recommends action to the legislature and the executive branch, sponsors legislation, and reviews the status of implementing recommendations.



State of Washington  
Legislative Budget Committee

506 16th Ave. S.E., PO Box 40910, Olympia, WA 98504-0910  
Phone: (206) 786-5171

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# **Residential Services For People With Developmental Disabilities - Phase 3**

## **Report 93-1**

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January 14, 1993

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**ACRONYMS AND TERMS USED IN THIS REPORT**

<b>DD</b>	Developmental disabilities (defined on page 3)
<b>DDD</b>	Division of Developmental Disabilities
<b>Downsizing</b>	Population reductions at the DD state institutions by moving residents to community placements.
<b>DSHS</b>	Department of Social and Health Services
<b>FTE</b>	Full time equivalent (referring to employees)
<b>FY</b>	Fiscal year
<b>GH</b>	Group home (usually five to eight residents). Operated by state contractors.
<b>ICAP</b>	Inventory for Client and Agency Planning, an assessment instrument of adaptive behavior and support needs.
<b>ICF/MR</b>	Intermediate Care Facility for the Mentally Retarded. Residences that meet the ICF/MR federal standards are eligible to receive Medicaid funding. Includes five of the six state institutions (all except Interlake) and contracted facilities in the community known as "TMRs."
<b>IMR</b>	Short form of "ICF/MR," referring to community group homes (five to eight beds) that meet the Medicaid ICF/MR standards. Operated by state contractors.
<b>ITS</b>	Intensive Tenant Support, a residential program operated by state contractors. Usually two or three people living in a rented house or apartment with staff support up to 24 hours a day.
<b>LBC</b>	Legislative Budget Committee
<b>"Movers"</b>	People who moved from the DD state institutions to community residential placements since December 1989.



<b>"Non-movers"</b>	Persons living in community residential placements who did not move from a DD state institution since December 1989. (Some "non-movers" previously lived at the state institutions.)
<b>RHC</b>	Residential Habilitation Center, that is, one of the six state institutions for people with developmental disabilities.
<b>SOLA</b>	State Operated Living Alternatives. Similar to ITS, but operated by state employees.

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# RESIDENTIAL SERVICES FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES - PHASE 3

## Summary

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**T**his report analyzes issues of legislative interest connected with "downsizing" of the state institutions for people with developmental disabilities (DD) by moving residents to community settings. The central question is how to achieve an equitable and cost-effective use of DD facilities, staff, and funding.

The report should be read in conjunction with the report by our consultants from the University of Connecticut (November 1992). The consultants developed original data on the service needs of people living at the state institutions, recent "movers" from the institutions, and other persons living in community residential placements. Generally speaking, the populations are not distinct in terms of problem behaviors, daily living skills, and needed services and supports. The consultants concluded that many people now living at the state institutions could be supported successfully in community placements.

In this report we focus on cost issues, such as the costs of the state institutions and the various types of community placements. In addition, we compare Washington and 14 other states in terms of downsizing activities, policies, and approaches.

Our key findings, combining work by the committee staff and consultants, are summarized in the *last chapter* of the report.

The LBC recommends that the legislature should consider enacting legislation in the 1993 session that gives clear policy direction on the role of DD community services and state institutions. The last chapter discusses the suggested key points of the legislation. The key concepts endorsed by the committee appear on page x of the report.

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## Overview

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## Recommendations

The LBC recommends that the Department of Social and Health Services (DSHS) should continue its planning efforts and prepare a specific management plan by March 1, 1993, to deliver more equitable and cost-effective services.

The LBC recommends that the legislature consider providing more flexibility in DD funding by reducing or eliminating the distinction between institutional and community funding, including a more budget-neutral approach to downsizing.

---

## Agency Response

The Department of Social and Health Services partially concurs with the report recommendations. A letter from the agency director appears near the end of the report.

This report was written by Matt Temmel and Gerry McLaughlin of the LBC staff. Cheryle Broom, Legislative Auditor, was the project supervisor. We appreciate the assistance in collecting information from other states by Tim Yowell, Senate Ways and Means staff, and Louise Bauer, staff of the National Conference of State Legislatures in Denver.

---

## Acknowledgments

Our consultants also helped to develop the information from other states, in addition to conducting extensive field work in Washington and advising us on the issues. We appreciate their contribution to a better understanding of the issues. We thank the members of the consulting team, including Jacqueline Dunaway, Karin Norton, Stephen Greenspan, and James Granfield of the University of Connecticut as well as Allen Buchanan of the University of Arizona and D.J. Bear of The Evergreen State College. We also appreciate the cooperation and assistance of DSHS staff in providing information and answering our many questions.

Cheryle A. Broom  
Legislative Auditor

*On January 14, 1993, this report was approved as amended by the Legislative Budget Committee and its distribution authorized.*

*Representative Helen Sommers  
Vice Chair*

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# RECOMMENDATIONS

## Summary

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### *Recommendation 1*

The legislature should consider enacting legislation in the 1993 session that provides policy direction on the role of DD community services and state institutions, as outlined on ~~page 53~~ the next page of this report.\*

Legislation Required:	Yes
Fiscal Impact:	Intended to be cost neutral.
Completion Date:	1993 Session

### *Recommendation 2*

DSHS should develop a management plan by March 1, 1993, for consideration by the LBC and the appropriate standing committees. The plan should be a specific operational plan to develop more cost-effective DD services that reach a larger population than now served. The plan should address the cost and management issues considered in this report and in the DD long-range plan, in the context of the recommended legislation.

Legislation Required:	No
Fiscal Impact:	None to develop plan. Implementation should be cost neutral.
Completion Date:	March 1, 1993

### *Recommendation 3*

The legislature should consider providing more flexibility in DD funding that reduces or eliminates the distinction between institutional and community services funds, including a more budget-neutral approach to downsizing.

Legislation Required:	Yes (state budget)
Fiscal Impact:	Intended to be cost neutral.
Completion Date:	1993 session

---

\* The Legislative Budget Committee approved the report after modifying the main ideas of the recommended legislation. See the next page for the key concepts endorsed by the LBC.

## Adopted by Legislative Budget Committee

January 14, 1993

### Key Concepts in Recommended Legislation On Developmental Disability Policy Issues

1. The legislature recognizes that living in home and community-based settings is most conducive to personal growth and independence and is generally more cost-effective than institutional care.
2. The legislature finds that state institutions for people with developmental disabilities may be needed for special populations who cannot be served in a cost-effective manner in home and community-based settings. The legislature also finds that many current residents at the state institutions could be supported successfully in home and community-based settings.
3. DSHS shall review the service needs of each resident of the DD state institutions and identify the level of services appropriate to maintain the person in the most normal and least restrictive setting that is consistent with the person's needs. If a community placement would be of equal or greater value to the resident than institutional care, DSHS shall move the person to a community placement if it is cost-effective to do so.
4. Services provided in both community and institutional settings should be designed to promote acquisition of independent living skills and self-sufficiency.
5. Funds reallocated from institutional services should be used to support both movers from the state institutions and people on waiting lists for community services.
6. The legislature recognizes the importance of developing (a) a resource allocation system based on individual need for supports and fair distribution of available resources, and (b) efficient and cost-effective service models and staffing levels. DSHS shall develop a resource allocation system, service models, and staffing levels so that services are provided in the most cost-effective manner possible.

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# BACKGROUND

## Chapter One

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**T**his is the third LBC report on residential services for people with developmental disabilities (DD). The report addresses issues of legislative interest connected with recent "downsizing" of the DD state institutions by moving residents to community settings. The central question considered in the report is how to achieve a more equitable and cost-effective use of DD facilities, staff, and funding.

The research was conducted by LBC staff and consultants from the University of Connecticut. The report considers issues that were identified in the LBC "Phase 2" report (January 1992) and then developed in this study's scope and objectives (Appendix 1). Four broad topics are addressed:

1. Review long-range planning information from the Department of Social and Health Services (DSHS), especially the service needs of persons in institutional and community programs.
2. Examine the costs of institutional and community placements.
3. Compare costs and examine selected program issues in Washington and other states.
4. Identify opportunities for more equitable and cost-effective use of resources.

---

## Introduction

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## LBC consultant report

This report should be read in conjunction with the report by our consultants from the University of Connecticut, which was presented to the LBC in October 1992. That report has been finalized and reissued under separate cover (November 1992).

The consultants developed original data on the service needs of people living at the state institutions, recent "movers" from the institutions, and other persons living in community residential placements. Generally speaking, the populations are not distinct in terms of problem behaviors, daily living skills, and needed services and supports. The consultants concluded that many people now living at the state institutions could be supported successfully in community placements.

As of early December 1992, the institutions have about 1,480 residents. Since late 1989, about 275 residents of the state institutions have been moved to community residential placements under the "downsizing" initiative authorized in the state appropriation acts.

This report focuses on cost issues and opportunities to develop more equitable and cost-effective services. The report is organized as follows:

---

## Contents of this report

- Chapter 2 is an updated and expanded version of a briefing paper presented to the LBC (September 1992) on the costs of DD residential placements.
- Chapter 3 compares placement costs in Washington and other states.
- Chapter 4 compares Washington and 14 other states in terms of downsizing activities, policies, and approaches.
- Chapter 5 summarizes the key findings and presents our conclusions and recommendations.

## OTHER STUDIES

Two other major studies have been conducted in 1991-92 concurrent with work by the LBC staff and our consultants:

1. A DSHS long-range plan on developmental disabilities. We have reviewed the October 5 draft. Our comments appear in the last chapter of this report.
2. Analysis of the variance in DD contract rates for contracted community residential placements. The study, completed in September 1992, was conducted by Sterling Associates under a consulting contract with the DSHS Division of Developmental Disabilities (DDD). The major findings from the analysis are discussed in Chapter 2 of this report.

## STATE STATUTES

According to RCW 71A.10.020, a "developmental disability" is a disability attributable to mental retardation, cerebral palsy, epilepsy, autism, or another neurological or other condition closely related to mental retardation. The disability must originate prior to age 18, be expected to continue indefinitely, and be a substantial handicap to the individual. A mentally retarded person is eligible for services if he or she has an IQ of 69 or less and significant deficits in adaptive behavior.

The statutes direct DSHS to "develop and coordinate state services" for persons with DD while cooperating with local authorities to establish services through "locally administered and locally controlled programs." DSHS has authority to contract with private providers for residential and other services. The state agency is also authorized to contract with the counties, which in turn subcontract with private providers for employment and day programs.

According to RCW 71A.12.010, "Services should be planned and provided as part of a continuum. A pattern of facilities and services should be established." DSHS operates the six DD state institutions, which are "permanently established" (RCW 71A.20.020). Another statute (RCW 71A.12.020) directs DSHS to:

---

Statutes  
give little  
policy  
direction



1. "... provide every eligible person with habilitative services suited to the person's needs, regardless of age or degree of developmental disability," subject to the availability of funds.
2. "... provide persons who receive services with the opportunity for integration with non-handicapped and less handicapped persons to the greatest extent possible."
3. "... establish minimum standards for habilitative services."

The state statutes on developmental disabilities are a patchwork of ideas that do not set a clear policy direction on many DD issues. Overall, the statutes provide little direction on who should be served and where, how, and to what extent they should be served.

## FUNDING AND PERSONS SERVED

Current expenditure authority for developmental disability services amounts to \$671 million during the 1991-93 biennium. The funds are used to support a biennial average of about 17,700 people found eligible for services and carried on the caseload of the DSHS Division of Developmental Disabilities. On a per client basis, the funding amounts to about \$19,000 per year for each eligible client and about \$27,000 per year for each client who actually receives services. As explained below, many eligible DD clients do not receive services from DSHS.

---

How many  
eligible DD  
clients  
receive  
services  
from DSHS?

Unduplicated counts of persons who receive services are not routinely available through the DSHS/DDD data systems. At the request of LBC staff, DSHS obtained an unduplicated count of the people who in December 1991 received residential services, day programs, other support services, and various combinations of services that were funded by DSHS. The exhibit on the next page summarizes the DSHS report.

Exhibit 1.1

**Unduplicated Count of Persons Served, December 1991**

	Age Groups			Total
	0-17	18-21	22+	
DDD Eligible Clients	5,641	1,359	9,873	16,873
Served by DSHS**	2,958	688	7,953	11,599
Unserved by DSHS	2,683	671	1,920	5,274

\*\* Includes Division of Developmental Disabilities, Division of Aging, Division of Mental Health, and Division of Children and Family Services. The following services are included:

1. Residential services (state institutions and 16 categories of community residences).
2. County programs (child development, group supported employment, individual employment, specialized industries, and community access).
3. Support services (family support, personal care, professional supports, and other supports through the Social Service Payment System).

Source: LBC staff analysis of DDD report dated 2 July 92.

As shown in the exhibit, the clients unserved by DSHS were as follows:

- Overall, 5,274 clients (31 percent of the eligible clients) did not receive services funded by DSHS.
- Most of the people unserved by DSHS were under age 22. We assume this group includes many students who are receiving special education services through the school districts and some who have left school and are without services.
- Of the population age 22 and over, 1,920 clients (19 percent of that age group) did not receive services funded by DSHS.

It should be noted that the DSHS "unduplicated count report" refers to only one month and has not been established as an ongoing report.

We should also consider that the unduplicated count of persons served simply indicates how many individual people received services. It does not indicate whether services are sufficient--that is, how many people were "underserved."

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## "Waiting lists"

The so-called "waiting lists" indicate the DSHS assessment of how many "unserved" or "under-served" people are in need of services. The following figures, referring to May 1992, appear in the draft DD long-range plan:

- About 2,000 individuals were waiting for a residential placement.
- About 3,800 people were waiting for an employment or day program.
- About 800 clients were waiting for family support services.

This high level of unmet need, or at least demand for services, may illustrate the importance of identifying opportunities for more equitable and cost-effective use of resources, which is a major topic in this report.

While it is apparent that many people are waiting for services, we also found in reviewing source documents that the "waiting lists" should be interpreted in general terms rather than as precise sets of figures:

- The figures are rough estimates by DDD in conjunction with the counties.
- The basis for the estimates is unclear.
- The estimates are not unduplicated counts of persons.

## THE "EQUITY ISSUE"

A main feature of the DD system is the "equity issue," that is, the disparity between the amount of funding and the number of people served in various settings. The relatively few people who live in the state DD institutions and community residential placements receive extensive services that consume a disproportionate amount of the funding. For example, as of early December 1992 the state institutions have about 8 percent of the eligible clients and will receive over 50 percent of the DD funding this biennium.

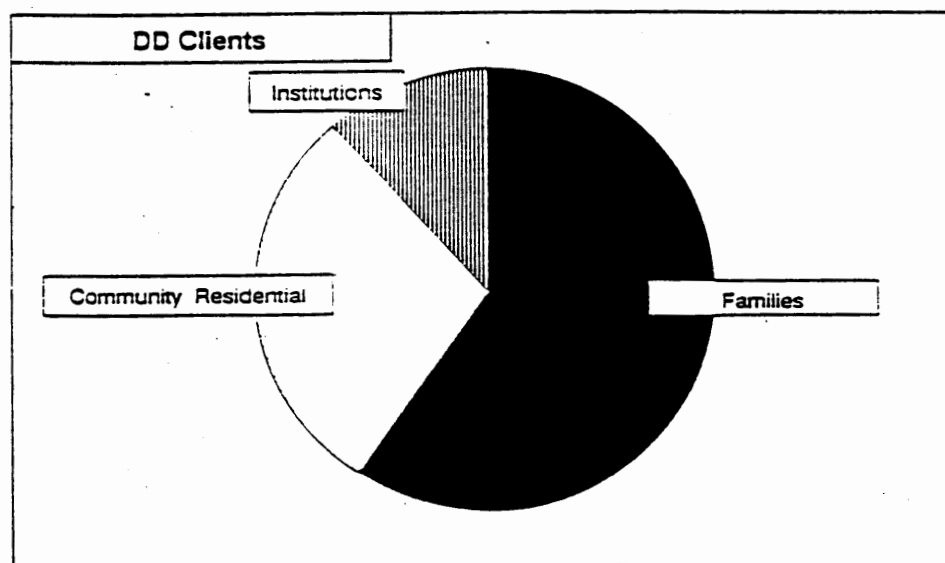
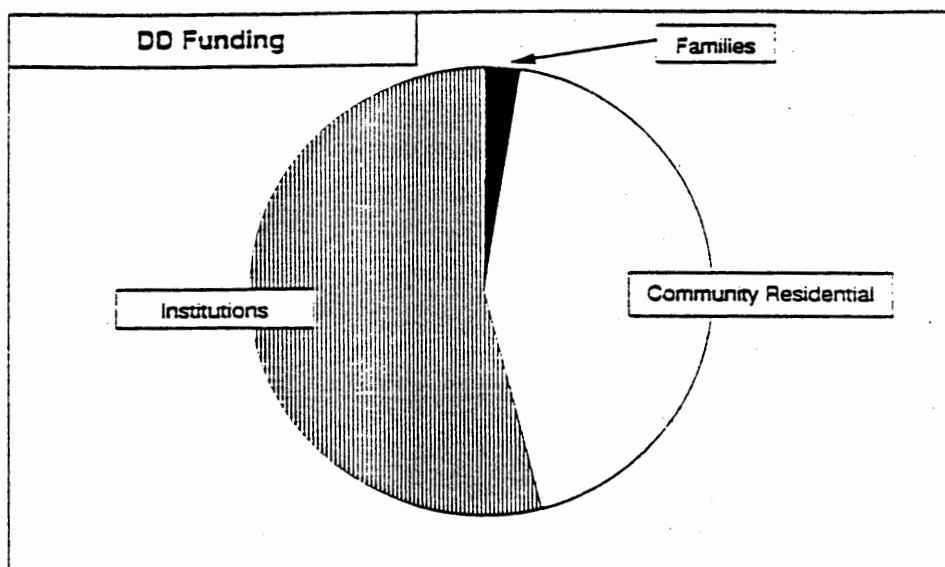
The following graphs are reproduced from our "Phase 2" report. They compare the estimated distribution of funding and clients in the state institutions, community residential programs of all kinds, and individuals living at home.

### Exhibit 1.2

#### Distribution of Funding and Clients by Residence Type

Division of Developmental Disabilities

1991-93 Budget / September 1991 Client Counts



Source: Prepared by LSC Staff from DSHS Data

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# COST ANALYSIS

## Chapter Two

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**I**n this chapter we identify and compare costs in DD residential settings. We focus on costs of the state institutions and of various community placements, especially those for "movers" from the institutions. We also explore reasons for the cost levels and suggest potential improvements which could result in expansion of services to a larger population through more efficient use of existing funds.

Our cost data refer to state fiscal year 1992 (July 1991-June 1992) for the following groups:

1. Residents of the six DD state institutions, or residential habilitation centers (RHC).
2. "Movers to ITS," that is, a sample of 52 people who moved in 1990 from the state institutions to intensive tenant support (ITS).<sup>1</sup> An ITS placement is a rented house or apartment usually with two or three residents and up to full time staff coverage. ITS is a contracted program and is the most common type of placement for recent movers from the state institutions.

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<sup>1</sup> The ITS sample included all people who moved from the RHCs to ITS between January and September 1990, excluding moves to Region 6 (because individual cost data was not available). We also collected FY92 cost data for movers to ITS between July and December 1991, but do not report the costs because: (1) Only nine people moved to ITS during that period, and (2) we could not separate start-up from ongoing costs.

---

## Introduction

3. "Movers to SOLA," that is, all 1991-92 residents of the State Operated Living Alternatives, which were started in 1990. The staff are state employees. The services and living arrangements are similar to ITS.
4. "Movers to Group Homes," that is, a sample of 20 movers from the state institutions to contracted small group homes in 1990 or 1991.<sup>2</sup>
5. "Small IMR," that is, 5 to 8 bed contracted group homes that meet federal ICF/MR standards for receipt of Medicaid funds. The same funding source and standards are used in five of the six DD state institutions.
6. In addition, we compare residential contract rates for the movers mentioned above and the comparable "non-mover" DD populations living in intensive tenant support and group homes.

Our consultants from the University of Connecticut found broadly similar disability levels and service needs among these six populations, with qualifications as noted in the consultant report.

## COST METHODOLOGY

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Data must  
be compiled  
to compare  
costs

"Costs" means public expenditures for residential and other supports. The cost elements differ in the various residential settings. Costs must be compiled from various sources to achieve comparability between settings.

The state institutions provide a comprehensive package of care, such as room and board, attendant care, medical and dental care, therapy, and vocational training or day programs. Expenditures are charged to the RHC budget units in the state accounting system. The expenditures are not attributed to individual clients and can be reported only on an aggregate or average client basis.

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<sup>2</sup> The sample included all persons who moved from RHCs to group homes between January and September 1990, and between July and December 1991, excluding Region 6.

Services for clients in contracted community placements are delivered by various agencies, not just the residential contractor. Our data for the movers refer to payments for residential contracts, therapy, other professional services, client allowances, medical and dental care, vocational or day programs, and various miscellaneous services. The data were collected on an individual client basis.

SOLA costs must also be compiled from various sources. Staff and some other costs are charged to the SOLA budget unit in the state accounting system. We consulted other sources and compiled on an individual client basis the costs of other services, such as therapy, medical and dental care, and day programs. In a similar manner, costs for the small IMRs were compiled from the appropriate data systems.

## **COSTS OF STATE INSTITUTIONS AND COMMUNITY PLACEMENTS**

The chart on next page shows the average costs per resident day during FY92 for various types of placements. Two lines in the chart are shaded. In our opinion, they are the most comparable figures. The annual figures are graphed on the page after the chart.

## Exhibit 2.1

## Average Costs per Resident Day, FY92

<u>Data Source</u>	<u>State Inst'n (RHC)</u>	<u>Movers to SOLA</u>	<u>Movers to ITS</u>	<u>Movers to GH</u>	<u>Small IMR (5 - 8 beds)</u>
Expenditures charged to unique budget units (less IMR tax)	274.83	317.86	0	0	134.53
Residential contract and other payments by SSPS (1)	0	5.37	186.75	115.83	0
Day program expenditures	0	20.77	18.26	12.65	10.15
Medical coupons	3.60	8.40	10.93	4.11	3.60
Transfer payments (2)	8.99	16.20	16.85	16.63	8.80
Client participation	-7.61	0	0	-8.31	-7.42
<b>SUBTOTAL</b>	<b>\$279.81</b>	<b>\$368.60</b>	<b>\$232.79</b>	<b>\$140.91</b>	<b>\$149.66</b>
<b>ANNUALIZED (366 DAYS)</b>	<b>\$102,412</b>	<b>\$134,908</b>	<b>\$85,201</b>	<b>\$51,573</b>	<b>\$54,776</b>
IMR tax (three months) (3)	11.67	0	0	0	6.12
Capital costs	20.88	0	0	0	0
DSHS central office overhead	10.15	1.06	1.06	1.06	1.06
DDD regional field services	0	2.90	2.90	2.90	2.90
<b>TOTAL</b>	<b>\$322.51</b>	<b>\$372.56</b>	<b>\$236.75</b>	<b>\$144.87</b>	<b>\$159.74</b>
<b>ANNUALIZED (366 DAYS)</b>	<b>\$118,040</b>	<b>\$136,357</b>	<b>\$86,651</b>	<b>\$53,022</b>	<b>\$58,465</b>

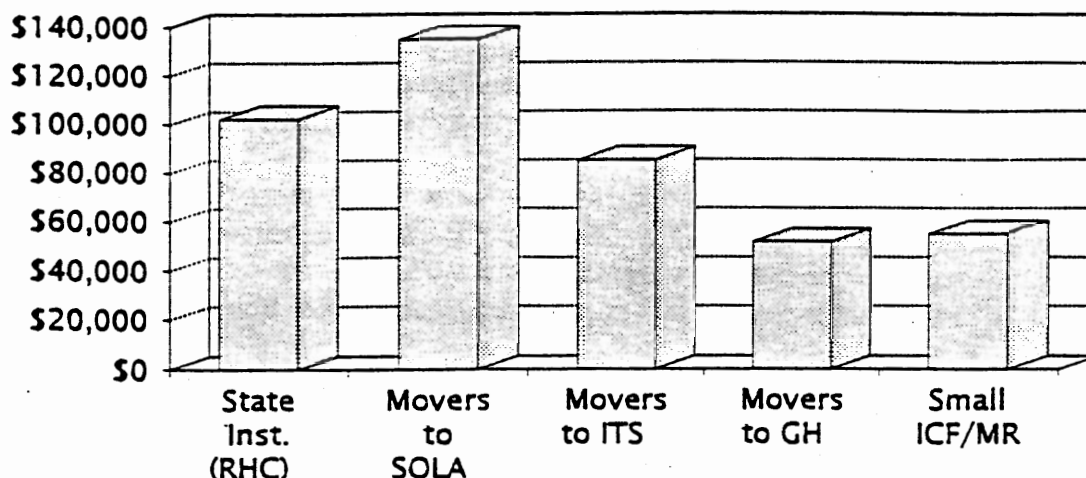
Notes

- (1) SSPS = Social Service Payment System. Includes payments for residential contract, staff add on, therapy and other professional services, miscellaneous services, and client allowance (rent and utility subsidy).
- (2) Transfer payments to clients include Social Security, Supplemental Security Income, food stamps, federal Section 8 (HUD) rent subsidy, and various other benefits. In RHCs, group homes, and IMRs, a high proportion of the transfer payments is recaptured by the state as "client participation" to offset the cost of care.
- (3) IMR tax for state institutions was actually charged at a higher rate (\$15.21) based on allotments rather than expenditures. Tax rate will be adjusted to reflect actual expenditures at close of biennium.



**Exhibit 2.2**

**FY 92 Average Annual Cost**  
(excluding IMR tax, capital and overhead costs)



The annual average costs per resident graphed above are as follows:

State institutions (RHCs)	\$102,412
Movers to State Operated Living Alternatives (SOLAs)	\$134,908
Movers to Intensive Tenant Support (ITS)	\$ 85,201
Movers to group homes	\$ 51,573
Residents of small IMRs	\$ 54,776

These figures exclude the IMR tax, capital and overhead costs, and the costs of field services. Those costs do not have clear counterparts in all settings. The details are shown in the lower part of the chart on the previous page.

These figures are a little higher than reported in our briefing paper to the LBC in September 1992 for two reasons: (1) Costs are reported here for all of FY92, not just the first six months discussed in the briefing; and (2) We have included some minor costs, such as transfer payments, not considered in the briefing.

## COSTS BY FEDERAL AND STATE SHARE

The federal government reimburses the state for approximately 55 percent of the costs of DD residential placements that qualify for federal funding support. The percentage changes slightly each federal fiscal year (October-September), which overlaps with state fiscal years (July-June). We estimated the cost shares for state fiscal year 1992 based on a federal matching rate of 54.79 percent, which is a combination of the two relevant federal year rates.

The same matching rate applies to authorized services at the state institutions (funded as Medicaid ICF/MR or nursing home facilities) and the community placements for the movers (funded under the Medicaid home and community based waiver, known as "CAP").

Some services currently qualify for federal financial participation if delivered in one setting but not in another. For example, vocational program costs at the institutions are subject to federal financial participation. In community placements funded under the CAP waiver, however, the federal government currently pays none of the costs of vocational employment programs in Washington, but does participate in the cost of "community access" day programs.<sup>3</sup> We thus separated the day program costs for the movers into the chargeable and non-chargeable costs.

---

Similar  
federal  
share for  
institutions  
and for  
"movers"

We computed the relative share of the costs in various settings paid by the federal and state governments, including "client participation" where applicable. Overall, we found that the federal government pays a similar percent of the costs for the institutions and the movers to ITS or SOLA. The following table shows the state, federal, and client shares of the costs of direct services in the various settings.

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<sup>3</sup> This practice reflects the limitations of the state's current CAP waiver, which was analyzed in our "phase 2" report. DSHS recently submitted to the federal government a waiver application that would cover employment programs for people who previously resided in ICF/MR facilities. The application follows the lead of many other states which receive federal funding under the waiver for community employment programs.

Exhibit 2.3

## Estimated State and Federal Cost Shares

	<u>State %</u>	<u>Federal %</u>	<u>Client %</u>
State Institutions (RHC)	44.02	53.35	2.63
Movers to SOLA	47.99	52.01	0
Movers to ITS	47.98	52.02	0
Movers to group homes	*	*	*
Small IMR group homes	45.19	50.00	4.81

\* Insufficient data to estimate shares.

Source: Calculated by LBC staff, based on cost data in this chapter and matching percentages supplied by DSHS Accounting Services.

The exhibit excludes capital and overhead costs, which either are not applicable or are not treated the same in each setting. If these costs are included, the percentages change very little; for example, the federal share for the RHCs rises from 53.35 to 53.49 percent.

The exhibit also excludes the portion of transfer payments (such as Social Security and Supplemental Security Income) that is retained by the clients. This income is treated differently in the various placements and therefore detracts from comparability across settings. If all transfer payments are included, the federal cost share increases by 1.5 to 3.0 percentage points in the various settings (e.g., 54.75 percent for RHCs). If both capital/overhead costs and full transfer payments are included, the relative shares change marginally (e.g., 54.76 percent for RHCs).

Thus it appears that the overall package of services provided to the movers to SOLA and ITS is reimbursed by the federal government at a level very close to the overall matching rate for institutional services.

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Various  
ways to  
compute  
cost shares

## DISCUSSION OF INSTITUTION COSTS

Considering only the basic operating costs charged to the RHC budget units, and excluding the new IMR tax, the costs of the state institutions have risen from \$169 per resident day in FY89 to \$275 per resident day during FY92. Appendix 2 shows FY92 costs by institution as reflected in the state accounting system.

The staffing level is the major factor in rising institutional costs. The overall staff to client ratio at the institutions was 2.44 to 1 in FY92, compared with ratios of 1.7 and 1.8 to 1 in the years prior to the current downsizing effort. The increased ratio is the result of the lower number of institutional residents combined with a major increase in the absolute number of institutional staff, as graphed on the next page.

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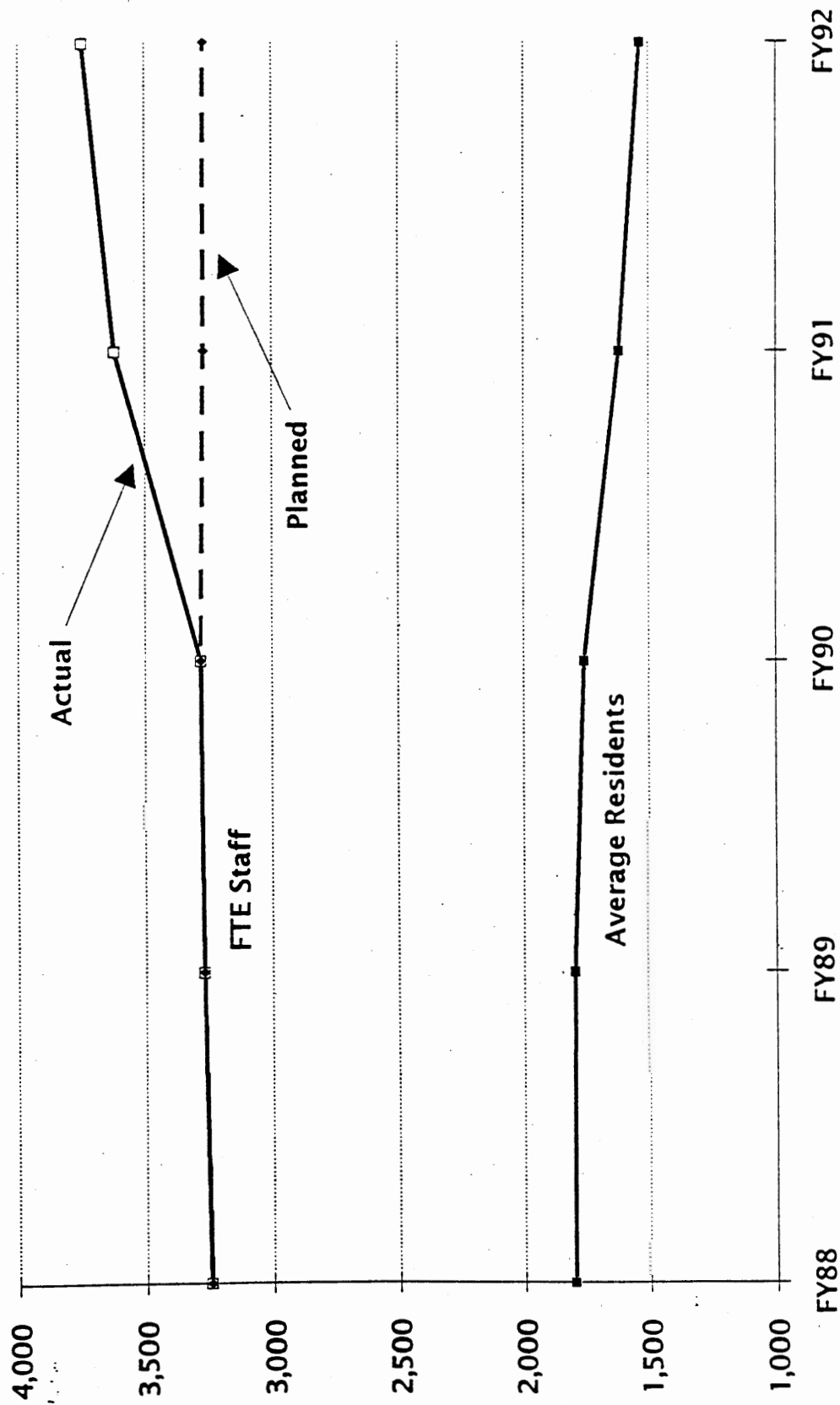
Large  
increase in  
staffing  
level

The downsizing policy adopted in 1989 was based on the premise that the staffing level would be *held constant* while decreasing the resident population through moves to community placements. That approach, which was recommended in the 1988 report by the Governor's Task Force, was intended to increase the staff-to-client ratio in order to meet federal active treatment standards. However, as shown in the graph on the next page, the staffing level has climbed from about 3,200 to 3,700. Most of the increase occurred in 1990 and 1991 when DSHS requested, and the legislature approved, a staffing increase in order to help retain Medicaid certification at Rainier School and other institutions.

As detailed in Chapter 3, the staffing ratio at the DD state institutions now ranks 12th highest in the nation, up from 34th as of 1987-88. State institutional costs per resident day now rank 13th highest in the nation, up from 22nd as of 1987-88.

Exhibit 2.4

## State Institution Staff and Residents, 1988 - 1992



## DISCUSSION OF SOLA COSTS

As shown on page 12, the expenditures charged to the SOLA budget unit amounted to about \$318 per resident day in FY92. If we add therapy, client allowances, day programs, medical care, and transfer payments, the total is about \$369 per resident day, excluding overhead and field services.

### SOLA costs are highest

The SOLA costs per resident day in FY92 were 31 percent higher than the DD state institutions, 58 percent higher than movers to ITS, 162 percent higher than movers to group homes, and 146 percent higher than residents of small community IMRs.

We computed SOLA costs based on the *actual occupancy* during FY92, which was roughly 90 percent of capacity. Budget staff in the Division of Developmental Disabilities prefer to represent SOLA costs on the basis of the maximum beds or "slots" that were available at a point in time, rather than the actual resident days over the course of the fiscal year. The DDD approach results in a lower cost per SOLA "slot," which is not comparable with other types of DD placements.

The SOLA program includes about 25 rented apartments and houses in Seattle, Tacoma, Yakima, and Spokane. They are mostly three-bedroom apartments or houses. As of early December 1992, SOLA had 78 residents.

The program was established in 1989 to:

- Provide a choice for parents/guardians of institutional residents who wanted a community placement staffed by state employees, and
- Lessen the impact of downsizing on institution employees, who were able to transfer to SOLA.

According to client assessment (ICAP) scores, the overall SOLA client population needs a level of service similar to that of the following populations: three institutions (Fircrest, Rainier, and Lakeland), group homes, and small community IMRs. Compared with the "movers to ITS," according to ICAP scores, the overall SOLA population needs a slightly higher level of service.

The main factors that seem to influence the higher SOLA costs are:

1. SOLA has a higher attendant care staffing level than at the state institutions and in contracted community placements.
2. SOLA has a high proportion of supervisors/managers to attendant care staff.
3. The labor-management agreement limits flexible assignment of staff and increases the amount of overtime pay compared with the private sector. Overtime added 11 percent to SOLA base salary costs in FY92.
4. State employee attendant care wages are about 30 percent higher than private sector.

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## Reasons for SOLA costs

The following comments are limited to the staffing level issue. The graph on the next page compares the planned and actual staffing ratio.

When SOLAs were being planned in 1989-90, DSHS and the state employees union agreed on a staffing pattern with two staff positions for every SOLA resident. In 1991, when LBC staff first looked into SOLA costs, DDD management told us they anticipated a staff to client ratio of 2.7 to 1 by June 30, 1991. In FY92, according to state accounting system data, the SOLA staff to client ratio was 3.11 to 1.

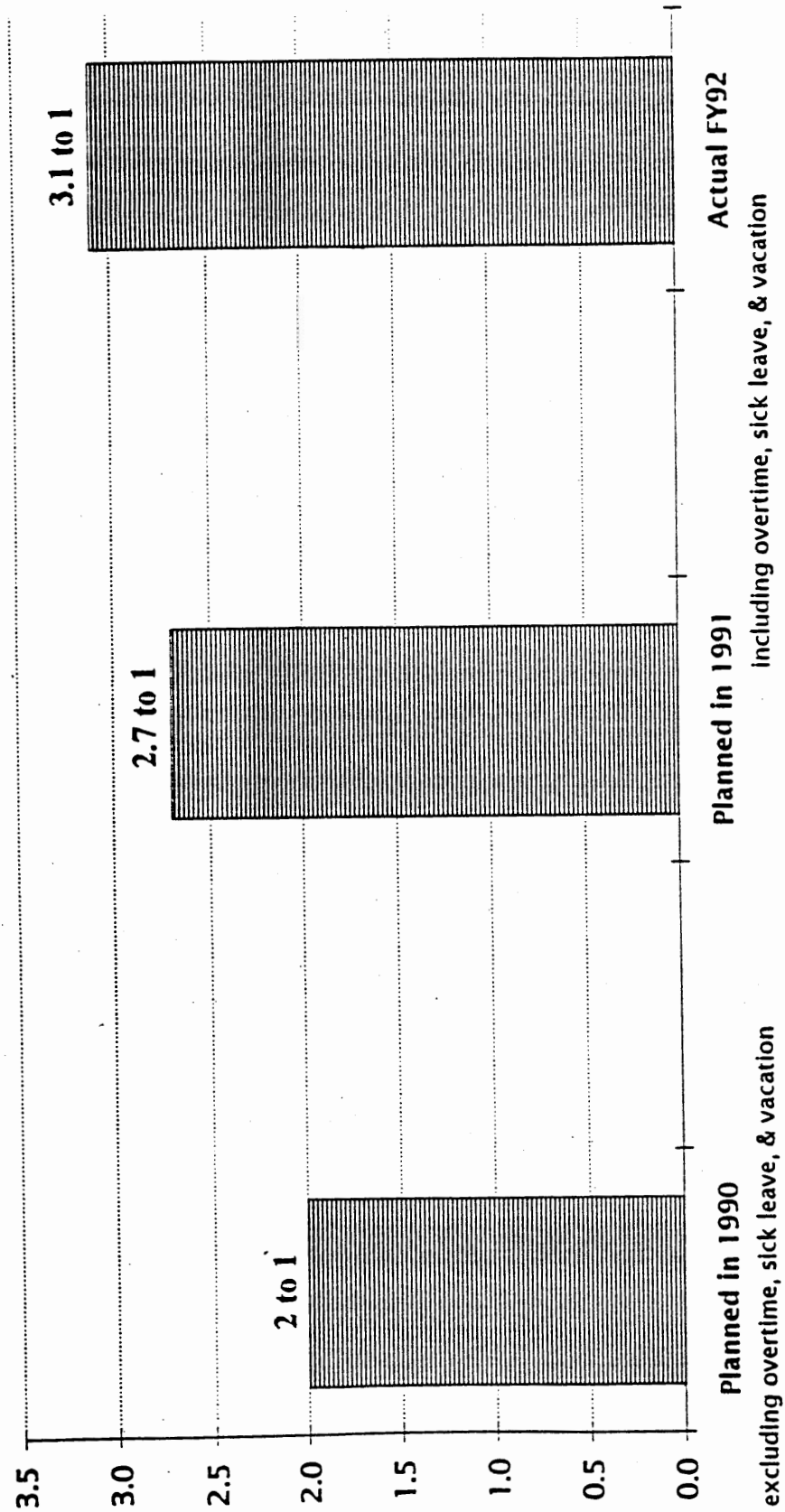
In full time equivalent (FTE) terms, we estimate that about 2.5 of the 3.11 SOLA staff per client are attendant care staff. Thus the FTE attendant care staff-to-client ratio in SOLA is about 2.5 to 1. At the state institutions, the comparable figure is about 1.13 to 1. In our sample of "movers to ITS," we estimate that the average contract rates provide funds for about 2.3 FTE attendant care staff per client.

We calculated these FTE staffing ratios from budget and contract materials. The figures differ from the actual on-site staffing level.

The next chapter of the report has a section comparing SOLA with programs in other states.

# SOLA Staff to Client Ratio: Planned and Actual

Exhibit 2.5





## MOVERS AND NON-MOVERS

As shown previously, average costs for the movers to contracted intensive tenant support and group home placements are much lower than SOLA and state institution costs.

A different perspective emerges when we compare the residential contract rates for the movers with the contract rates for the "non-movers" in the same settings. According to the ICAP scores and the in-depth case studies by our consultants, the service needs of the mover and non-mover populations are similar for the settings that were studied. However, we found that the authorized service levels are quite different. The "movers to ITS," for example, are authorized an average of about 13.2 staff hours per client per day, versus about 9 hours for the general ITS population.

This difference in service level amounts to a major difference in the contract rates set for movers and non-movers. The residential contract rates for the movers to ITS and group homes are *about 55 percent higher* than rates for the non-movers in the same settings.

Apparently, the contract rates for the movers were set by a combination of available dollars, provider funding requests, and DDD judgments about needed supports.

## RESIDENTIAL CONTRACT RATES

Residential contract rates comprise the major portion of the costs in the various community placements. The Intensive Tenant Support rates in FY92 ranged from \$41 to \$257 per day. Rates for group homes ranged from \$32 to \$170 per resident day. (The rates are now higher because of a vendor increase that took effect on July 1, 1992, with a further increase scheduled for January 1, 1993.)

Under contract to DDD, Sterling Associates recently completed a "Tenant Support Rate Reimbursement Analysis" which examined the wide variability in contract rates. The analysis was based on the costs of service reported by the providers and could find no factor or set of factors that adequately explained the cost variations. The variation was not related to program size, geographic area of the state, or other quantifiable factors thought to affect rates.

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Rates for  
movers are  
55 percent  
higher

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DDD  
consultant  
study: no  
explanation  
for cost  
variances

The work by the DDD consultant is compatible with the findings of our consultants from the University of Connecticut that DDD needs a systematic way to assess client service needs and assign resources accordingly.

As a first step, Sterling Associates recommended that DDD develop service standards to provide a rational basis for the vendor reimbursement system. Sterling Associates also concluded that the rate setting system should be based on individual client need. As discussed in the next chapter, several other states have developed rate setting systems based on levels of needed service that are identified through assessment instruments.

## VACANCY PAYMENTS

**\$1.8 million  
paid for  
empty beds**

Exhibit 2.5 below summarizes FY92 payments to DD residential contractors for vacant (empty) beds in the intensive tenant support, regular tenant support, and group home programs. The total vacancy payments during the year were \$1,824,903. (This amount is equivalent to annual contract payments for 55 people.) The beds remained unfilled for various administrative and case management reasons.

Exhibit 2.6

### State Contract Payments for DD Residential Vacancies, FY92

<i>Region 1 Spokane</i>	<i>Region 2 Yakima</i>	<i>Region 3 Everett</i>	<i>Region 4 Seattle</i>	<i>Region 5 Tacoma</i>	<i>Region 6 Olympia</i>	<i>State Total</i>
\$261,547	\$29,383	\$441,793	\$462,887	\$184,403	\$444,891	\$1,824,903

Source: Data from Division of Developmental Disabilities. Includes payments under the vacancy codes for Tenant Support (Regular and Intensive) and group homes.

The vacancy payments were not eligible for federal cost sharing and thus had to be supported totally by state general fund dollars. DDD recognized this aspect of the problem and adopted a new policy in early 1992. According to DDD, vacancy payments were eliminated and replaced by a "cost of care adjustment," which increased vendor rates by spreading the vacancy payments over the number of filled beds.

This change in DDD policy permits the state to claim federal financial participation in the cost of empty beds. The change also: (1) inflates residential contract rates for vendors with empty beds, and (2) does not appear to promote reducing the vacancy rate.

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# WASHINGTON AND OTHER STATES: COST COMPARISONS

## Chapter Three

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**I**n this chapter we compare costs of DD residential placements in Washington and other states. Four topics are discussed:

1. Costs of state institutions.
2. Costs of state-operated community placements, such as SOLA, and other methods of alleviating the impact of downsizing on institution employees.
3. Costs of contracted community placements, especially for "movers."
4. Rate setting and contracting approaches in other states.

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## Introduction

### STATE INSTITUTIONS

To compare Washington's DD state institutions with those in other states, we reviewed 1992 survey data in conjunction with 1987-88 information on institutional staffing ratios and costs per resident day.<sup>1</sup> These sources show how Washington ranks among the states on these two key indicators.

According to the survey data, Washington's 1992-93 costs per resident day are 13th highest among the states, up from 22nd

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<sup>1</sup> The 1992 data were collected by Gary Smith of the National Association of State Mental Retardation Program Directors and are unpublished as of this writing. The 1987-88 data were published by Braddock et al., in *The State of the States in Developmental Disabilities* (1990).

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## Washington institutions move up in cost rankings

highest as of 1987-88. The reported cost for Washington was \$312 per resident day (excluding the IMR tax). The national average was \$227.

As shown earlier in the report, the staffing level at the RHCs has increased by some 500 positions since 1990, while the residential population was falling. According to the survey data, the staffing ratio (total staff per resident) for Washington's DD state institutions ranks 12th highest in the nation, up from 34th as of 1987-88. The reported figure for Washington as of July 1, 1992, was 2.47 staff per resident, compared with the national average of 2.05.

Appendix 2 has charts, based on the 1992 survey data, listing the states with the highest reported staffing ratios and costs per resident day.

## SOLAS IN OTHER STATES

As we showed in Chapter 2, costs for Washington's SOLA program were about \$318 per resident day in FY92, plus therapy, day programs, transfer payments, and other costs. The total cost was about \$369 per resident day, excluding small allocated costs for agency overhead and DDD field services.

To place SOLA in a national perspective, we identified all states that have state-operated community residential placements for people with developmental disabilities. The defining characteristic of a state operated community residential placement program is that attendant care services are provided directly by state employees in community-based settings.

We found that:

1. Programs somewhat similar to SOLA exist in nine other states: Arizona, Connecticut, Massachusetts, Minnesota, Mississippi, New Jersey, New York, Oregon, and Rhode Island. Details are shown in Appendix 2.
2. Of the ten states with state-operated community placements, the SOLA costs per resident day (\$369) are the second or third highest. Massachusetts appears to have the highest costs (about \$466), followed by Washington (\$369) or Oregon (about \$360). Costs from the states have different cost elements and are not exactly comparable.

3. Organizational factors, such as staffing levels and size of the living unit, are more important than wage levels in explaining the variations in the costs of state operated community placements.

We studied SOLA costs in relation to published 1990-91 survey data from other states on state employee wage rates for DD direct care staff.<sup>2</sup> We concluded that wage differences among the states did not explain much about the cost differentials. The average wage in Washington was \$9.61 an hour, which ranked fifth highest among the ten states with state-operated community placements. The four states with *higher* average wages were New York (\$9.77), Rhode Island (\$10.16), Minnesota (\$11.16), and Connecticut (\$12.84). The state operated community placements in those four states, despite the higher wage rates, have lower costs per day than SOLA.

The staffing level has a clear impact on program costs. In FY92 SOLA had about 2.5 attendant care staff per resident. Roughly comparable figures from other states are as follows: Rhode Island, 1.17; Minnesota, 1.62; and New York, 1.73. Those states have lower costs than SOLA.

We found higher ratios in the two states, Massachusetts and Oregon, where the costs either exceeded or were similar to SOLA. Massachusetts has a ratio of about 3 attendant care staff for each resident. In addition, the professional support staff (nurses and therapists) are all state employees.

In Oregon, where the costs are roughly at the same level as SOLA, the seven state operated group homes have about 3.1 attendant care staff per resident. In addition, state employees provide nursing care and vocational training. The Oregon clients in the state-operated homes may be more severely disabled than the SOLA residents. Oregon sources told us that many of the 35 residents are either medically fragile or behaviorally challenging. Few SOLA clients fit those descriptions.

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<sup>2</sup> David Braddock and Dale Mitchell, *Residential Services and Developmental Disabilities in the United States: A National Survey of Staff Compensation, Turnover and Related Issues* (American Association on Mental Retardation, 1992).

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SOLA  
staffing  
level is  
higher than  
in most  
states

Another major cost factor is the number of persons per living unit. SOLA appears to be the only state-operated community placement program in the nation to use a three-person apartment or house as the program standard for persons transferred from the state institutions. Other states typically use larger living units, such as four- to six-person homes, which permit more efficient and less costly staffing patterns.

Finally, Washington and Massachusetts seem to be the only states in which costs per day of the state-operated community placements exceed those of the respective state institutions.

## ALTERNATE USES OF STATE INSTITUTIONAL EMPLOYEES

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### Approaches in other states

Other states have faced the issue of how to provide for state institutional employees who are affected by institutional downsizing or closure. Various ideas and approaches are discussed in this section.

Rhode Island and Minnesota have agreed with their state employee unions that no permanent employee of a DD state institution will be involuntarily laid off or suffer a reduction in pay as a result of downsizing or closure.

In Rhode Island, where the one DD state institution is scheduled to close in 1993, the main employee safeguard is transfer to a state-operated community placement. This appears fiscally feasible because the "state ops" have a "lean" staffing ratio and the costs are close to the rates paid to the contracted providers.

In Minnesota, the state-operated community placements are expensive compared with the private sector, and it is unclear whether they will be expanded in the near future. The state has agreed to offer "enhanced separation options" to certain institutional employees affected by downsizing. The options include paid insurance benefits for a period of time, a separation payment of up to \$7,500, and tuition at a college or university.

Minnesota and Missouri utilize current or former institutional employees as crisis intervention or respite care workers in local communities. The number of staff is thought to be small (about 30 in Missouri, unknown in Minnesota).

If downsizing continues, another possibility that could be explored by DSHS is to transfer institutional staff to case manager duties as a way of alleviating the high caseloads in field services offices.

Various states have offered early retirement packages, transfer rights to other institutions, relocation payments, job retraining programs, and modification of personnel specifications so that employees can transfer to other state jobs.

Many states appear to have made few or no special provisions for the employees when institutions are downsized or closed. Employee attrition permits a state to move a certain number of residents each year without having to lay off staff. If the moves are planned well in advance, the institution knows whether to fill vacant staff positions with permanent or temporary employees.

According to published survey data, the annual turnover rate at the DD state institutions in Washington was about 18 percent for the direct care staff as of 1990-91.<sup>3</sup> More recent data on attrition in the major institutional job classes that was provided to us by DSHS did not use a common definition of attrition. Thus it could not be used to analyze how many people could be moved from the institutions without requiring staff layoffs.

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## Staff attrition at institutions

## COSTS FOR MOVERS TO CONTRACTED COMMUNITY PLACEMENTS

We obtained information from 12 other states on residential and day program contract rates for recent movers from the state institutions. Compared with the averages in our sample of Washington "movers to ITS," we found:

1. The typical residential program contract rates for movers in all 12 states were *lower* than the Washington average.

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<sup>3</sup> Braddock and Mitchell, *Residential Services and DD in the US*, page 337.



2. The day program rates per resident day in all 12 states were *higher* than the Washington average.
3. Overall, the combined residential and day program rate was *higher* in Washington than in all 12 states.

The details are shown in Appendix 2, Table 5.

**Rates for  
Washington  
"movers"  
appear  
higher than  
in other  
states**

We did not explore the differences in day program contract rates. The following discussion is limited to residential rates. The discussion assumes that the needs of movers in Washington and the other states are broadly similar--that is, that there is no inherent reason connected with client need why contract rates should be higher in Washington than in the other states that we studied.

Two major components in residential contract rates are:

- An allocation for direct care staff wages and benefits, which was \$10.79 an hour for FY92 (increased to \$11.11 in July 1992 and scheduled to rise to \$11.78 in January 1993). This amount is set in Washington by the legislature in the state budget.
- The level of service, which is expressed in Washington as contracted hours per client per day. This level is established by the DDD field services offices in the rate setting process.

The higher residential contract rates for the Washington movers reflect, in part, the generally higher level of staff wages and benefits (\$10.79 an hour) built into the Washington rates. The staff wages/benefit rate component is lower in most of the 12 states (e.g., North Dakota @ \$7.56, Kansas @ \$8.56, and Michigan @ \$9.06).

The wage/benefit component of contract rates is often discussed, at the price of overlooking the level of service (staff hours). The average level of service for the Washington movers to ITS appears high compared with other states. This conclusion is based on our estimate of staff hours derived from staffing ratio figures supplied by other states. The staffing ratio is another way of expressing staff hours per client per day.

For the Washington movers to ITS, the average was 13.2 contracted staff hours per client per day (basic hours plus "staff add on"). These authorized hours of care provide for 1.1 attendant care staff around the clock for every two clients (two-person ITS setting) and 1.65 staff around the clock for every three clients (three-person ITS setting).

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## Staff hours

Typical ratios for movers in other states are one attendant care staff for every two clients *during at home and awake hours* (that is, excluding the time that clients are at day programs and excluding sleeping time, when ratios are much lower). In contrast, the Washington average funded ratios cited in the previous paragraph are considerably "richer" because they apply 24 hours a day.

It is notable that the *highest* contract rates and service levels for movers in some other states are similar to the *averages* for the Washington movers to ITS sample. In Colorado, for example, the highest contract rate and service level is called "deinstitutionalized high needs" and applies to 45 to 50 people statewide. About half of the movers in the Washington sample have a higher staffing level than the Colorado maximum.

Similarly, in New Hampshire the highest residential rate and service level ("behavioral/medical personal care") applies to 57 people in the state and provides a lower staffing level than authorized for many "movers to ITS."

The above information refers to movers. It is an open question how the service levels established for the general ITS population (not just movers) compare with service levels for similar populations in other states.

The Washington ITS program has about 1,000 clients, who receive on average about nine staff hours per client per day. This is much higher than the average service levels we found in other states that provide residential support in two- or three-person settings. However, it is unclear whether the populations in those programs are similar to ITS clients and thus whether the service level comparisons are appropriate. This question could be studied by DSHS when developing the management plan recommended in this report.

## RATE SETTING AND CONTRACTING APPROACHES

As shown in Chapter 2, the wide variation in Washington contract rates (and thus in service levels) could not be explained by a DDD consultant based on the providers' reported costs, program size, geographic area of the state, or other quantifiable factors. The consultant concluded that a new rate setting system should be based on individual client need.

### Approaches to consider

We encountered two approaches in other states that might be considered for possible application in Washington:

1. Several states have recently established rate setting systems in which the needed hours of service are identified by administering the ICAP, Developmental Disability Profile, or a similar assessment instrument. This approach is used in New York, Kansas, California, Florida, and a few other states. The instrument is periodically administered to identify changes in client need and adjust the rates.
2. North Dakota, Missouri, and Nevada use *individual contracts* for each client in their supported living program. The purpose is to individualize services as much as possible. According to sources in North Dakota and Missouri, the contracts are revised at least once a year, and sometimes as often as every three months. The individualized approach is said to permit contract adjustments (often downward) as client needs change and other supports are found through the "generic" service systems.

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# WASHINGTON AND OTHER STATES: DOWNSIZING ISSUES

## Chapter Four

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**T**he comparisons in this chapter are based on (1) review of the research literature, and (2) detailed information from the 14 states listed in Exhibit 4.1 on the next page.

Information on the 14 states was collected by LBC staff and consultants from the University of Connecticut, with assistance by staff of the Senate Ways and Means Committee and the National Conference of State Legislatures.

We selected the 14 states for study because they appeared to have either generally "progressive" DD systems, innovative specific programs, or other features worth exploring.

The 14 states were not necessarily intended as a representative sample of the nation because there are no clear selection criteria. However, as shown in the graph on the next page, the 14 states are balanced in terms of the percentage of DD funding devoted to institutional or community services. The exhibit refers to FY88, which was the most current data available at the start of this study.

This chapter covers five topics in Washington and other states:

1. Downsizing trends
2. State policies and approaches
3. Outcomes for movers to community placements
4. Outcomes for institutional residents
5. Parent/guardian issues

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## Introduction

Exhibit 4.1

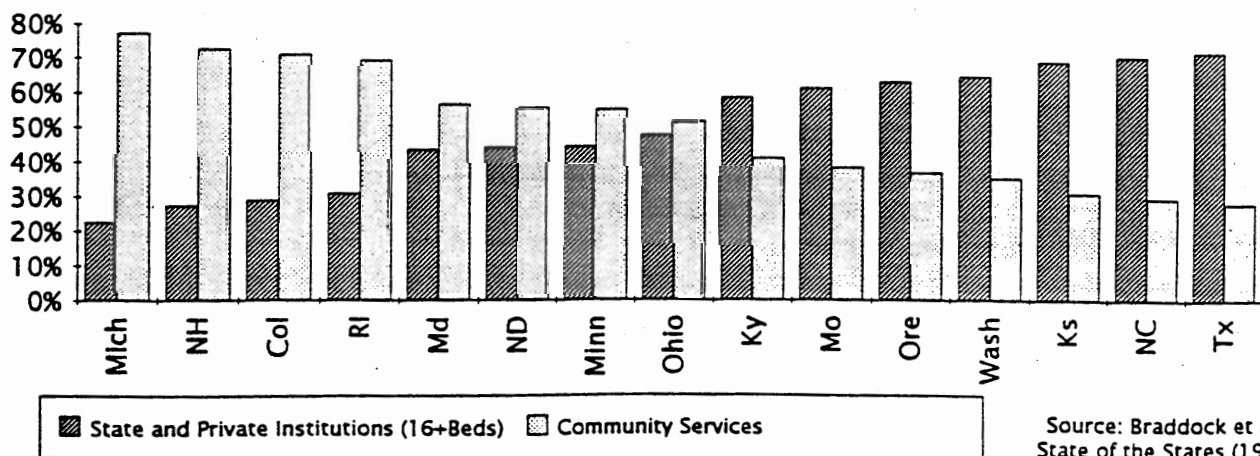
## DD State Institutions in Selected States

The number of residents is the figure available when we contacted the state DD agencies between late September and early November 1992. The states are ranked by residents per 100,000 state population.

	<u>State</u>	<u>State DD Institutions</u>	<u>Number of Residents</u>	<u>Residents per 100,000 State Population</u>
1	New Hampshire	0	0	0.0
2	Michigan	3	550	5.9
3	Colorado	3	276	8.4
4	Rhode Island	1	133	13.3
5	Oregon	2	528	18.6
6	Maryland	5	964	20.2
7	Kentucky	3	770	20.9
8	Ohio	13	2,294	21.1
9	Minnesota	7	997	22.8
10	North Dakota	1	173	27.1
11	Missouri	5	1,433	28.0
12	Washington	6	1,482	30.4
13	Kansas	3	912	36.8
14	Texas	13	6,538	38.5
15	North Carolina	5	2,572	38.8
	TOTAL	65	17,050	23.9

Exhibit 4.2

## Percent of DD Expenditures in Selected States for Institutional and Community Services, FY88



Source: Braddock et al.,  
State of the States (1990)

## DOWNSIZING TRENDS

Nationally, the number of residents of DD state institutions has declined from 195,000 in 1967 to about 85,000 today and is projected to decline to 55,000 by the year 2000. The national reduction in institutional populations is closely associated with development of community-based service systems.

Since 1970 approximately 35 DD state institutions have closed in 20 states, and at least 15 more are scheduled to close by 1995. New Hampshire closed its one DD state institution in 1991, as did the District of Columbia. A few other states have been building up their community systems and are expected to close their state institutions completely within the next two or three years. New York has announced that all of its DD state institutions will close by the year 2000.

The amount or rate of DD institutional downsizing in Washington has been fairly low compared with other states. Between 1984 and 1988 the DD state institutional population in Washington declined by a total of 3.3 percent over four years, which ranked 45th in the nation.<sup>1</sup> Since 1989, when "Project Options" began, the institutional population in Washington has declined by 275 people, or about 15 percent over three years. Most of the 14 states that we studied have downsized at a faster rate.

The chart on the next two pages compares Washington and the 14 other states in terms of downsizing activities, related state policies, and parent/guardian consent issues.

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Less  
downsizing  
in  
Washington  
than in  
other states

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<sup>1</sup> Braddock et al., *State of the States in Developmental Disabilities*, page 13.

## Exhibit 4.3

## Downsizing Activities and Policies in Washington and 14 Other States

<u>State</u>	<u>Downsizing Activities</u>	<u>State Policy</u>	<u>Parent/Guardian Consent</u>
New Hampshire	Total community system. Closed the one DD state inst'n in 1991.	Least restrictive. In-home better than out of home placements.	No longer an issue.
North Carolina	Minor downsizing. Exits partially offset by entries.	Unclear.	Not in statute. Movers have parental/guardian consent.
North Dakota	Moved 1,000 from inst'n in 12 years to comply with court order (ARC lawsuit).	Least restrictive appropriate setting. "DD bill of rights" since 1981.	Not in statute. Movers have parental/guardian consent.
Ohio	One inst'n (of 13) is closing. Closure plan announced in 1989 led to major controversy.	Institution lost Medicaid certification. State decided to close. Lawsuit opposing closure was won by state.	Not in statute. Result of lawsuit allows state to move residents over parent/guardian objections.
Oregon	Moved 1,300 from the two state inst'ns since 1984, under HCFA and Justice Dept pressure. Will move 55 more in 1993.	Least restrictive environment. Community system is primary. Inst'ns are back-up facilities. New community services split between waiting list and movers from inst'ns.	Because of federal pressure, choice is about locations and roommates, not whether to leave the institution.
Rhode Island	140 movers in last year. The state's one DD institution will close in 1993. Plan was adopted in 1986.	Policy is to develop the community system, making inst'ns unnecessary. Statute says 6 or fewer unrelated persons with MR or MI are a family for zoning purposes. Solved siting problem for group homes.	Minor issue. Few parents in RI are guardians.
Texas	Two of 13 state inst'ns are slated to close. Gradual downsizing. Net decline = 150 a year (225 movers offset by admissions).	Federal lawsuit instigated downsizing.	Not in statute. Movers have parental/guardian consent.

## Exhibit 4.3

## Downsizing Activities and Policies in Washington and 14 Other States

<u>State</u>	<u>Downsizing Activities</u>	<u>State Policy</u>	<u>Parent/Guardian Consent</u>
Washington	Moved 275 from state inst'ns since late 1989. Also many movers from large IMRs and nursing homes. Large expansion of community placements.	Unclear statutes. Downsized under budget initiative.	Parent/guardian choice of placement is heavily emphasized. "Froberg law" gives appeal rights and power to delay or prevent move to community.
Colorado	Major downsizing. State has 3 small inst'ns (1 with no residents on campus) limited to hardest to serve.	Least restrictive alternative in statute. Clear preference to community services. Admission to institution requires court order.	Not in statute. Movers have parental/guardian consent.
Kansas	Major downsizing. Closed 1 inst'n in 1988.	5 year legislative plan says close another inst'n. Governor disagrees.	Not in statute. Movers have parental/guardian consent.
Kentucky	No downsizing. Agency proposed to close 1 of the 3 state inst'ns, defeated by legislature.	Admission to inst'n requires court order. Terms of the MR involuntary commitment statute have been in litigation.	Not in statute. Movers have parental/guardian consent.
Maryland	Major downsizing. May consolidate some of the 5 state inst'ns.	Pressure to downsize from parent lawsuit and Dept of Justice.	Not in statute. Movers have parental/guardian consent.
Michigan	Many inst'ns closed. Some of remaining 3 will probably close. Governor committed to privatization.	Least restrictive alternative. Preference to in-home and community placements.	Resident, nearest relative, and guardian have right of appeal if object to move. State wins admin. appeals.
Minnesota	Moved 1,600 from inst'ns since 1980, including 400 since 1989.	Least restrictive alternative. 1990 law says move inst'n res. to community, subject to approps. Admission to inst'n requires court order & review.	Not in statute. Movers have guardian consent. ARC influential in convincing parents of benefits of community living.
Missouri	Moved about 500 from state institutions since 1988.	Least restrictive setting. Admissions to DD inst'ns are limited to criminal cases and a few intensive medical and behavior cases.	Not in statute. Movers have parental/guardian consent.



## STATE POLICIES AND APPROACHES

In eight of the 14 states, the statutes indicate that people with developmental disabilities should live in the "least restrictive" setting in which they can receive needed services or supports. This and other related language gives explicit preference to community-based over institutional services. Three examples are mentioned below.

### Policies in three other states

In 1981 North Dakota passed a "DD bill of rights," which says in the first section: "All persons with developmental disabilities have a right to appropriate treatment, services, and habilitation for those disabilities. Treatment, services, and habilitation for developmentally disabled persons must be provided in the least restrictive appropriate setting." Since 1980 North Dakota has moved about 1,000 institutional residents (85 percent) to community placements. Downsizing was prompted by a lawsuit against the state institution.

Minnesota has reduced its state institutional population by over 1,600 (62 percent) since 1980. Legislation was enacted in 1991 which anticipates transferring most institutional residents to community placements, subject to available funding. Screening teams were directed by statute to review all institution residents and "identify the level of services appropriate to maintain the person in the most normal and least restrictive setting that is consistent with the person's treatment needs."

Oregon, under pressure from federal authorities, has moved about 1,300 people since 1984 from the two DD state institutions to community placements. The current institutional population (528 residents) is about one-third of the 1984 level. In 1989 Oregon enacted DD statutes which contain two key policies:

- "The role of [DD state institutions] shall be as specialized back-up facilities to a primary system of community-based services . . . ."
- New community services should be developed and divided equally between people on the waiting list for services and people moving from the state institutions.

Downsizing or closure of institutions is intended to result in redistribution of DD funding to the far greater number of individuals wanting services in home and community settings. The research literature refers to this process as reallocation of institutional resources.

Since 1989 Washington has used a different approach. Downsizing of state institutions has been funded with "new money" to support the movers in their community placements. At the same time, institutional costs have been rising on a total and per resident basis. Based on our information from other states, another approach to downsizing seems possible.

First, it is important to move people from the institutions in *large groups*, which would facilitate timely closure of institutional cottages and administrative units. Second, it is important to plan *when* residents will be moved from the institution so that managers know when to fill vacant staff positions with temporary or permanent staff. Third, it is essential to avoid staffing increases at the institutions, such as the 500 staff added at the RHCs in 1990-91.

Finally, because of the large differences in institutional and community costs, sources in other states suggested that it should be possible to develop a more "budget-neutral" approach to downsizing.

## OUTCOMES FOR MOVERS

Our consultant found favorable outcomes for people in Washington who moved recently from the state institutions to community placements. The consultant case studies included 67 movers since January 1990. According to the consultant report, the great majority of these movers have made observable and documented gains in personal self-control, ability to communicate, and acquisition of various daily living skills. The consultant also reported marked decreases in maladaptive behaviors for 36 of the 42 movers with documented histories of those problems.

Many studies have reached similar conclusions about movers in other states. A policy research brief by researchers at the University of Minnesota summarizes the results of 18 studies in various states between 1976 and 1988 of people who moved from institutions to community living arrangements. The research brief is reproduced in Appendix 4 of this report.

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Downsizing  
in  
Washington  
could be  
more  
budget-  
neutral

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## Significant gains for movers

In general, the 18 studies found that movers usually make statistically significant gains in adaptive behavior (skills of daily living). More specifically:

- Thirteen of the 18 studies found statistically significant improvements either in overall adaptive behavior or in some of the seven "domains" of adaptive behavior (such as self-care or social skills).
- Only one of the 18 studies found a decrease in any domain of adaptive behavior. The domains with decreases were vocational behavior and recreation/leisure. The decreases were not statistically significant.
- About half of the studies reported changes in maladaptive behavior after the move to the community, but the changes were not statistically significant.

All 18 studies included baseline data collected before the move, as opposed to retrospective gathering of data about behavior while at the institution. It is also notable that eight of the 18 studies were designed so that the movers were compared with a control group with similar characteristics which remained at the institution. All eight of these studies reported statistically significant greater gains in adaptive behavior for the movers relative to their counterparts who remained at the institutions.

## OUTCOMES FOR INSTITUTIONAL RESIDENTS

We made many inquiries about recent research-based publications on outcomes for institutional residents and the role of institutions in the service delivery system. We were able to find only one recent publication of this kind, a book entitled *Institutions for the Mentally Retarded: A Changing Role in Changing Times*, edited by Marie Skodak Crissey and Marvin Rosen (Austin, Texas, PRO-ED, 1986). The various contributors to this work say little about outcomes for institutional residents. The publication mainly concerns the changing role of institutions.

The preface states (page xi): "While much has been written about the beneficial effects of community living arrangements, few have

dared to explore the salutary potential of institutions." The contributors present institutions as potential resource centers that could offer genetic counseling, vocational training, respite care, and other services to the surrounding community. In short, DD institutions could become "the core of a continuum of services." However, few details are given to illustrate this concept. The editor explains that the "blueprint" for the institution of the future is "offered not as a blueprint to be followed" but as a rough outline to be developed (page 137). As residential facilities, the book presents institutions in the future as a "backup" or "last resort" resource (page 149).

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## "Salutary potential of institutions"

## PARENT/GUARDIAN ISSUES

Many parents, guardians, and other relatives of residents of DD state institutions have been intensely involved in downsizing issues in Washington and other states. Downsizing in some states has been initiated in response to lawsuits filed by parent organizations interested in improving conditions at state institutions or forcing their closure. Other parents and organizations have been strongly opposed to deinstitutionalization.

The next few pages of the report consider the following topics: (1) parent-guardian satisfaction with institutional and community placements, as reported in the research literature; (2) parent/guardian appeal rights in other states when a relative is moved from a state institution; and (3) analysis of Washington's "Froberg law." As discussed later, the Froberg law gives parents of institutional residents certain appeal rights and the power to delay or prevent a change in placement.

### Research Literature

Many research studies have been conducted to assess parent satisfaction with institutional and community placements for people with developmental disabilities. The results of 23 studies were summarized by Larkin and Lakin in 1989.<sup>2</sup> The various

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<sup>2</sup> Sheryl A. Larson and K. Charlie Lakin, "Parent Attitudes about Their Daughter's or Son's Residential Placement before and after Deinstitutionalization," Policy Research Brief, Nov. 1989, Vol. 1, No. 2, University of Minnesota Institute on Community Integration.

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## Parent satisfaction

studies surveyed parents at different times, such as when the son or daughter was living at a state institution, or in a community placement, or before and after a move from an institution to the community.

Several studies surveyed parents while their son or daughter was living at the institution. These studies found that, on average, about 90 percent of the parents had a positive opinion of the institution and about 75 percent opposed a change in placement.

Other studies surveyed parents after their son or daughter moved from a state institution to a community placement. These studies found that, on average, 88 percent of the parents had a positive opinion of the new placement and services.

Finally, four major studies published since 1985 included surveys of parents before and after the move. The studies were conducted in Pennsylvania, Massachusetts, Louisiana, and Illinois. These studies found high average levels of parent satisfaction both with the institution before the move (85 percent) and later with the community placement (89 percent). When the parents of the movers were asked retrospectively about the institutions, the satisfaction with the institutions declined to an average of 52 percent.

## Appeal Rights in Other States

In contacting authorities in our 14 selected states, we inquired about appeal rights and practices when the state wishes to transfer a resident of a DD state institution to a community placement. The results are briefly summarized in Exhibit 4.3 earlier in this chapter. We also made the same inquiries to national experts who are familiar with other states. We found that:

- All states gain consent of a legal guardian prior to moving an institutional resident, as required under guardianship laws.
- All states provide appeal rights as part of the service planning process. The service plan, including a change in placement, can be appealed.

- Washington's "Froberg law" is unique in providing specific statutory appeal rights that have had the effect, as implemented by DSHS, of allowing parents or guardians to decide whether institutional residents should move to community placements.

We found two other states, Massachusetts and Michigan, with special appeal provisions regarding deinstitutionalization.

A state regulation in Massachusetts provides an appeal process when the state decides to move a resident from a DD state institution. According to Massachusetts sources, there are a few appeals each year and the state wins virtually all of them, on the grounds that community placement is of equal or greater value to the resident than the institutional services.

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## Appeals in Massachu- setts and Michigan

Michigan has a state statute which stipulates that a resident of a DD state institution may be transferred to another state institution or to the community "if the transfer would not be detrimental to the resident." The statute directs the agency to provide an appeal process. According to the agency regulation, a resident may be transferred "for good and sufficient clinical reasons." Appeal rights are provided to the resident, nearest relative, and guardian.

The appeal process in Michigan has been used extensively as the state has closed DD institutions. According to Michigan sources, there are 20 to 25 appeals a year, and the state wins 90 percent of the cases at the administrative level. The key evidence is that the community placement is of equal or greater value to the resident, as illustrated by:

- The higher ratio of direct care staff in the community placement, and
- The greater opportunities in the community for integration and normal living, both of which are mentioned in the Michigan statutes.

## Parent/Guardian Appeal Rights in Washington

Various provisions of the Washington statutes, known as "Froberg law," give appeal rights to various persons who oppose a state decision to move a resident of a state institution to a community placement. Key provisions of the statutes (RCW 71A.10.050 and 71A.20.080) are:

### "Froberg law"

- Right to an administrative hearing.
- Right to judicial review.
- No transfer to the community while the appeal is in process, including administrative hearing decisions that are appealed to the courts.
- DSHS "has the burden of proving that the specific placement decision is in the best interests of the resident."

The Froberg law has not been used extensively since its enactment in 1983. Central office staff of DDD told us they could recall only one administrative appeal, while staff at one of the state institutions knew of several appeals in 1983 or 1984. Both sources agreed that the state lost the cases and then stopped trying to move people from the institutions if a parent or guardian was opposed.

When DSHS decides to transfer an RHC resident to a community placement, the agency is required under the statutes to notify certain persons of the impending transfer and advise them of their right of appeal, first at an administrative hearing and then through the court system. However, it is unclear *who* has appeal rights, as explained below.

Under the original 1983 statute, the persons with appeal rights were the resident, parents of minor residents, and guardians or other court-appointed representatives of adult residents. Since 1989, when the law was amended, DSHS is required to notify these persons plus at least one other person listed in RCW 71A.10.060, in the following priority order:

- Parents of residents age 18 and over.
- "Other kin" of residents.
- The Washington protection and advocacy system.

- A person, excluding DSHS employees, who in the opinion of DSHS "will be concerned with the welfare of the person."

Because of the construction of the statutes, it is not clear whether the Froberg appeal rights apply to the persons added in 1989 or only to those persons specified in the 1983 legislation. The 1989 revisions were part of a general reordering of the DD statutes, and it is unclear whether the legislature intended to make a substantive change on appeal right issues.

The statutes provide that DSHS shall not implement the new placement while an appeal is pending. This includes judicial review. We were told that this feature of the law could delay downsizing for months or years, depending on court calendars and how far an appeal is pursued.

Some sources suggest that it is unreasonable to require DSHS to prove that a placement is in "the best interests of the resident." However, as noted earlier, the Massachusetts and Michigan state agencies are able to demonstrate that the community placement is of equal or greater value to the resident.

According to DSHS, about two-thirds of the parents or guardians of DD institutional residents oppose or would oppose moving the person to a community placement. DSHS also indicates that about 70 percent of the current institutional residents could be supported successfully in community placements, according to professional clinical judgment.

It is unclear what happens when a resident wishes to move from the institution but a parent, relative, or guardian opposes a change in placement. The state has no involuntary commitment law that applies to the DD institutions.

Parent/guardian issues also affect the level of service in community placements, rather than just moves from an institution to the community. Our consultants from the University of Connecticut found that 23 percent of the individuals in their case studies of community residents were receiving more staff support than needed. One factor in maintaining the high service level was the wishes of parents or guardians.

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Parent  
choice can  
conflict  
with  
clinical  
judgment



We recognize the importance of involving parents and guardians in placement decisions, and we believe that DSHS and other interested parties could do much to foster better understanding on these issues. The report by our consultant includes practical suggestions from other states, such as more communication between parents of movers and parents of institutional residents.

Current state policy relies on "parent choice," rather than professional clinical judgments, as the major factor in deciding who should move from an institution to a community placement. The policy limits the state's ability to provide services in the most cost-effective manner. Parents and guardians are concerned about the security and continuity of care when an institutional resident is transferred to a community placement.

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## Continuity of care

The legislature could address this concern by changing the law. By statute, the state could assure that any person transferred from a DD state institution to a community residential placement shall be provided for life with an appropriate level of attendant care and with needed medical and dental services, therapy, and support services.

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# CONCLUSIONS AND RECOMMENDATIONS

## Chapter Five

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**A**s shown in the previous chapters, the DD system faces major policy, budget, and management issues. In this chapter we review the key findings of this study and the consultant's report. We then present our conclusions and recommendations.

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### Overview

#### KEY FINDINGS ON POLICY ISSUES

1. Washington's statutes on developmental disabilities do not set a clear policy direction in which the DD system should be moving. The statutes have little influence on who receives services and where, how, and to what extent people are served.
2. Under the current system the relatively few people who live in the DD state institutions or community residential placements receive extensive services that consume a disproportionate amount of the funding. For example, as of December 1992 the state institutions have about 8 percent of the eligible clients and over 50 percent of the DD funding. Many eligible people receive few or no services.
3. According to ICAP scores and other data, the service needs of many people living at the state institutions and in community placements are similar. Many institutional residents could be supported successfully in community placements.
4. According to the consultant case studies, most people who moved recently from the state institutions to community placements have benefited in terms of greater personal self-

control, ability to communicate, and/or acquisition of other skills. Many studies have reached similar conclusions about movers in other states.

5. Many people living in community placements receive a higher level of attendant care staff support than residents of the state institutions. This may help to explain the favorable outcomes for the movers.
6. Parent/guardian choice is a critical factor in Washington in deciding who moves from a DD state institution to the community. Washington gives more weight to parent/guardian choice than other states.

## KEY FINDINGS ON COST ISSUES

1. Downsizing has been funded since 1989 with "new money" for community program development, in addition to the increased funding appropriated for the institutions. The legislature in cooperation with DSHS could develop a more budget-neutral approach.
2. Costs per resident day for the DD state institutions are higher than the costs for recent movers to contracted community placements, but lower than the costs for the movers to SOLA.
3. Institutional costs have risen sharply in recent years, and risen more in Washington than in most other states. According to survey evidence:
  - a. In cost per resident day, Washington now ranks 13th highest in the nation, up from 22nd as of 1987-88.
  - b. In staff to client ratio (total institutional staff per resident), Washington now ranks 12th highest in the nation, up from 34th as of 1987-88.
4. The SOLA costs are much higher than contracted ITS placements because of higher salaries and benefits, terms of the labor-management agreement, and a higher staffing level. The higher staffing in SOLA includes (a) more

attendant care staff per resident, and (b) a higher ratio of supervisors and managers to attendant care staff. Client differences between SOLA and ITS do not explain the different staffing levels.

5. Costs for the movers to contracted ITS placements, although much lower than institutional and SOLA costs, are about 55 percent higher than the "non-movers" in ITS. The service needs of the two populations are similar, according to ICAP scores and case studies. The cost differences reflect the higher service levels authorized for the movers (over 13 staff hours per client per day, versus about 9 hours for the non-movers). This suggests the need for a more equitable method for setting service levels and contract rates based on individual client need.
6. The service levels and contract rates for the movers to ITS are also high compared with recent movers in other states. None of the other states from which we obtained information seem to authorize such a high average level of service. This finding also suggests the need for a rate setting method based on individual client need.

## KEY FACTORS AFFECTING COMMUNITY SERVICES AND COSTS

1. Heavy caseloads (two to three times higher than in most states) impede case managers' ability to work proactively, develop new community based resources, and allocate resources efficiently. There may be opportunities to obtain more case managers at little or no additional cost to the state, such as accessing federal funds for targeted case management and transferring institutional staff to assistant case manager positions.
2. Allocation decisions in DD field services offices are influenced most by (a) emergencies, (b) persistent advocacy, and (c) membership in a priority group defined by the legislature in the state budget, such as movers from the state institutions. The state agency needs a more systematic and equitable way to set priorities and allocate resources.

3. Little systematic information about individual client needs is now available to use in setting or adjusting service levels for movers and other persons living in community placements. This limits the state's ability to set contract rates based on individual client needs.
4. In case studies of 118 community placements, our consultants from the University of Connecticut found that 23 percent were receiving more staff support than necessary. Because of heavy case manager workload and other factors, the current system does not promote adjusting authorized staff hours to the needed level as individual needs change.
5. A consultant to DDD found wide variation in residential contract rates but could not explain the variation based on the providers' reported costs. The variation was not related to program size, geographic area of the state, or other quantifiable factors thought to affect rates. The DDD consultant did not examine costs in relation to client need, because no data were available. The consultant concluded that DDD should develop service standards and a new rate setting system based on individual client need. Several other states have developed rate setting systems based on levels of needed service that are identified through the ICAP, DD Profile, or other standardized assessment instruments.
6. Virtually all new funding made available for residential placements in recent years has been devoted to small living units for 2 or 3 persons. Many other states use 4 to 6 person settings, which can be staffed more efficiently and have lower costs per resident.

## CONCLUSIONS

As reflected in our findings, many opportunities exist to move toward a more equitable and cost-effective use of DD facilities, staff, and funding. The need for a policy change is suggested by the benefits for people who have moved recently from the institutions, the relatively small amount of downsizing in Washington compared with other states, the disproportionate amount of funding devoted to institutional care, and the generally greater cost-effectiveness of home and community-based services.

Progress will require a coordinated effort by the legislature, governor, DSHS, and the many stakeholders in the DD system. We suggest that the legislature work cooperatively with the other parties and consider the following approach:

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## Recommended approach

1. **State Policy:** Enact legislation in the 1993 session that gives clear policy direction on the role of DD community services and state institutions.
2. **State Management:** Obtain from DSHS a management plan by March 1, 1993 to develop more cost-effective DD services that reach a larger population than now served. The plan should be a specific operational plan that addresses the cost and management issues considered in this report and in the DD long-range plan, in the context of the recommended legislation.
3. **State Budget:** Consider providing more flexibility in DD funding that reduces or eliminates the distinction between institutional and community funds and includes a more budget-neutral approach to downsizing, contingent on the management plan.

## State Policy

Statutes in some other states, but not in Washington, recognize that the great majority of people with developmental disabilities should and do live in home and community-based settings. Our DD statutes tend to reflect viewpoints that predate the development of special education programs and community services in the 1970s. Those developments have made it possible for people with major disabilities to live successfully outside of institutions.

The Washington statutes are based on the concept of a "continuum" (RCW 71A.12.010). The continuum ranges from intensive treatment and care at state institutions to lower levels of service in community programs. This concept is obsolete for at least three reasons:

- The "continuum" is organized around buildings and the providers of service, rather than people who need support. It assumes that people with DD must live in "facilities," rather than in houses or apartments like other people.

- The "continuum" confuses the facility with the level of service, rather than recognizing that a high or low level of service can be given in any setting.
- The "continuum" does not exist in practice. As shown by the ICAP scores and case studies, the populations in all settings that were studied have a wide and overlapping range of service needs. Generally speaking, the populations in the various settings are not distinct.

The "continuum" concept implies that people in institutions *should have* the greatest needs and thus perhaps the highest costs. In practice, however, many institutional residents have needs that are indistinguishable from those of people being served successfully in community settings. The data strongly suggest that community-based settings are generally more cost-effective in meeting people's needs.

If the legislature wishes to set a clear policy direction for the state, it could adopt legislation with the points outlined in the exhibit on the next page.

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## Recommended legislation

The policy direction suggested in the exhibit is not completely new to the Washington statutes. For example, under RCW 71A.12.020, one objective of state services is to "provide persons who receive services with the opportunity for integration with non-handicapped and less handicapped persons to the greatest extent possible." The suggested legislation would clarify and develop that idea.

The legislation, while aiming to provide a policy basis for downsizing the state institutions, would not be intended to close all institutions. The available data suggest that too many people now live at the state institutions. The data do not speak to other issues, such as how many institutions are needed, how many residents should live there, and which special populations should be the focus of institutional service. Probably the most practical approach for the near future is to consolidate the institutions.

**Exhibit 5.1****(See Note \* Below)****Key Concepts in Recommended Legislation**

1. People with developmental disabilities should live in normal home and community-based settings to the extent possible and receive treatment and supports consistent with their needs, subject to available funding.
2. DSHS should review the service needs of each resident of the DD state institutions and identify the level of services appropriate to maintain the person in the most normal and least restrictive setting that is consistent with the person's needs.
3. Any person transferred from a DD state institution to a community residential placement shall be provided with an appropriate level of attendant care and with needed medical and dental services, therapy, and support services. In addition, any person in a community residential placement (but not previously in a state institution) who leaves that placement shall have similar assurances of continuing support if needed.
4. The future role of the DD state institutions should be evaluated to determine if they can serve as a resource to back up the primary system of home and community-based services.
5. Funds reallocated from institutional services should be used equally (or in some other proportion) to support movers from the institutions and people on waiting lists for community services.
6. The legislature recognizes the importance of developing a resource allocation system that is based on individual need for supports and on the fair distribution of available resources.

\* The Legislative Budget Committee approved the report after modifying the key concepts shown on this page. See page x, printed on blue near the beginning of the report, for the key concepts adopted by the LBC.



## Management Plan

Many of the findings in this report are also recognized in the DSHS long-range plan on developmental disabilities. For example, the long-range plan draft of October 5 speaks to the following concepts or points that are similar to the material in this report:

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Long-range  
plan makes  
many  
suggestions

- Develop a more equitable and cost-effective system that provides needed supports to a larger population than now served.
- Facilitate and help develop community capacity to support people with developmental disabilities.
- Provide services and supports adequate to meet individual needs in the least restrictive setting.
- Determine methods and tools to do assessments and reviews of individual need against defined priorities.
- Reassess the service needs of everyone currently receiving services. Change service priorities and levels as identified by reassessments. Phase in changes in service levels.
- Allocate resources based on individual need while recognizing the competing needs of other persons.
- Assess current service models and identify ways they may be more cost effective while continuing to meet individual needs.
- Identify specific "core" services to be offered. Consider putting a lid on selected core service costs.
- Cover more services under the Medicaid home and community-based waiver programs.
- Develop a data system for management and budget information that has baseline information and tracks costs and benefits.

- Review current state regulations, such as nursing and boarding home standards, that may increase DD costs without corresponding benefits.
- Improve coordination between residential and day programs by changing contracting structures as needed.

These suggestions from the long-range plan are compatible with the findings by the LBC staff and our consultants. The next crucial step is to prepare a specific management plan. The plan should address the major problems identified in this report and be made available to the LBC and the fiscal and policy committees by March 1, 1993.

The plan should show how, when, where, and at what cost the agency would develop a more equitable and cost-effective system that provides needed supports to a larger population than now served. The plan should address issues raised in this report (such as SOLA costs and costs for movers to ITS) that are not explicitly mentioned in the long-range plan.

Finally, the plan should be framed in the policy context of the suggested legislation (outlined above), even though the legislation could not be enacted by March 1, 1993.

## State Budget

State budgets provide appropriations for DD services divided into institutional and community services categories. The appropriations, especially enhanced funding, are often subject to directives that the funding is "provided solely" for a particular population or program, such as movers from the state institutions or high school graduates entering the adult community services system.

We understand the reasons for this approach. However, it may have some disadvantages:

- It retains and promotes the categorical structure of services, which limits management's ability to allocate resources as needed.

---

Need for a  
specific  
management  
plan

- It attempts to expand certain DD services by providing more money, without also requiring cost efficiencies and more cost-effective services.

The fiscal committees may want to consider another funding approach that provides more flexibility to management, if the legislature concurs with the management plan suggested above.

---

## More flexible funding needed

The most far reaching approach would be to eliminate the distinction between institutional and community services appropriations and allow DSHS to allocate resources as needed. On a more limited basis, the same thing might be done on a pilot basis in one or perhaps two regions of the state. Overall, after reviewing the management plan, the legislature should consider providing greater fiscal flexibility so that the agency has the opportunity to develop more cost-effective services.

The legislature may also want to change its funding approach to downsizing. Since 1989 the movers have been funded with "new money" for community program development. The level of new funding to support the movers appears too high, in that the movers are similar to people served successfully in the community at far lower rates. At the same time the institutional staffing levels have been increased by some 500 FTEs, even though the number of residents has declined. Thus costs have increased dramatically for both institutional and community services.

The legislature in cooperation with DSHS could develop a more budget-neutral approach to downsizing. Some essential points are:

- Give DSHS the authority to transfer DD institutional funds to community programs as people are moved. (This is a limited version of eliminating the distinction between institutional and community services.)
- Set contract rates for the movers consistent with their needs.
- Require that downsizing achieve major savings at the institutions.

- Retain individual planning for the movers, but reduce costs by improved planning. For example, move people in large groups at set dates, so that managers know when to hire permanent or temporary staff at the institutions.

## RECOMMENDATIONS

### *Recommendation 1*

*The legislature should consider enacting legislation in the 1993 session that provides policy direction on the role of DD community services and state institutions, as outlined on page 53 of this report.\**

### *Recommendation 2*

*DSHS should develop a management plan by March 1, 1993, for consideration by the LBC and the appropriate standing committees. The plan should be a specific operational plan to develop more cost-effective DD services that reach a larger population than now served. The plan should address the cost and management issues considered in this report and in the DD long-range plan, in the context of the recommended legislation.*

### *Recommendation 3*

*The legislature should consider providing more flexibility in DD funding that reduces or eliminates the distinction between institutional and community services funds, including a more budget-neutral approach to downsizing.*

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\* The LBC modified this recommendation. See page x, printed on blue, near the beginning of the report.

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# SCOPE AND OBJECTIVES

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## Appendix 1

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### *SCOPE*

This study focuses on residential placement issues for people with developmental disabilities (DD). The central question addressed by the study is how to achieve a more equitable and cost-effective use of DD facilities, staff, and funding.

### *OBJECTIVES*

1. **Review DSHS long-range planning materials on the following:**
  - a. How many people with DD receive the various types of services?
  - b. How many people are unserved or under-served?
  - c. What does available data indicate about the characteristics of current institutional residents compared with those recently transferred from institutions to community settings?
  - d. How many institutional residents could be transferred to community settings, as recommended in individual habilitation plans or based on other appropriate data? How many residents require institutional care?
  - e. What does available data indicate about the characteristics of others eligible for DD services?
  - f. On what basis are resources allocated to DD programs?

2. **Analyze the costs of institutional and community placements. ("Costs" means expenditures by the state and federal governments.)**
  - a. What are the average costs per resident of the various types of residential placements? This includes institutions, intensive tenant support, tenant support, state operated living alternatives, small group homes, large group homes, alternative living, and family support.
  - b. What are the costs for special populations (such as medically fragile clients, those with severe behavioral problems, and those diagnosed with mental retardation and mental illness)?
  - c. What are the standards for community residential placements, such as health and safety, staffing levels, and quality assurance? How do the standards affect costs?
  - d. How do the costs of DD residential placements compare with costs for other DSHS clients?
  - e. How do the costs of DD residential placements in Washington compare with those in other states?
3. **Analyze the following issues with regard to Washington and other states that are substantially changing the role of institutions.**
  - a. For clients recently transferred from institutions to community settings, what is known about the impact on client health, safety, living skills, and satisfaction?
  - b. How do community programs in Washington for clients recently transferred from institutions compare with those in other states that are moving in a similar policy direction? (Some essential comparisons are service models, residents per living unit, amount of client supervision, staff hours, day program types and hours, and available cost data.)
  - c. What approaches have been used in other states to minimize the impact on state institutional employees?
  - d. What approaches have been successful in alleviating the concerns of parents or guardians about moving clients from institutions to community residential services? What is the role of parent choice of placement in other states compared with Washington?

4. **Identify the major opportunities to achieve a more equitable and cost-effective use of DD facilities, staff, and funding without compromising client health and safety.**
  - a. What should be the role of institutions in serving people with developmental disabilities? To what extent are institutions needed? Would redistribution of institutional funding result in more cost-effective services to a larger population?
  - b. What alternatives can be developed for state institutional employees? Should state operated living alternatives be continued and expanded?
  - c. How much emphasis should be placed on the intensive tenant support model for persons transferred from institutions to community placements? Would more use of other models achieve more cost-effective services?
  - d. How can resources be redistributed to give greater support to families caring for a DD client at home?
  - e. What other options are available to move toward a more equitable and cost-effective use of DD facilities, staff, and funding?

4/14/92

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# AGENCY RESPONSE

## Appendix 2

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- Department of Social and Health Services





STATE OF WASHINGTON  
DEPARTMENT OF SOCIAL AND HEALTH SERVICES  
*Olympia, Washington 98504-0095*

January 7, 1993

RECEIVED

JAN 7 1993

LEGISLATIVE

State of Washington  
Legislative Budget Committee  
506 East 16th  
PO Box 40910  
Olympia, WA 98504-0910

Dear Ms. Broom: 

This letter is in response to the Residential Services for People with Developmental Disabilities - Phase 3 Preliminary Report dated December 18, 1992. I appreciate the effort and the analysis that went into preparing this Phase 3 report. The department's response to the preliminary recommendations are as follows.

Recommendation #1 - Partially Concur

The department agrees that clarification of the role of the community and institutional services would be important for legislative consideration during the 1993 session. Given the transition to a new executive, we are unable to commit at this time that the policy direction and funding priorities from the incoming administration would be wholly consistent with the issues raised in the last chapter of the report. We will ensure that the transition team for the incoming administration has access to the Phase 3 report for their consideration.

Recommendation #2 - Partially Concur

The department supports the development of a management plan to implement executive and legislative policy. As previously stated, it is not possible to commit to develop a management plan by March 1, 1993 that addresses services "that reach a larger population than now served".

Recommendation #3 - Concur

The department supports consideration by the legislature for additional flexibility in funding.

Legislative Budget Committee  
January 7, 1993  
Page Two

Residential programs that support people with developmental disabilities are very dynamic and have a long history of serving people with a wide range of needs through a variety of residential models. This report provides a "snapshot" of the residential program at a specific point in time and primarily focuses on people moving from state institutions.

Prior to the time period studied in this report, there were many factors which affected the residential services system in this state. Some of these include: (1) the national philosophical and program shift of supporting people in their own living arrangements instead of congregate settings; (2) the 1989 State of Washington Interagency Task Force Report to the Governor which proposed how to respond to revised federal standards if Intermediate Care Facilities for the Mentally Retarded (ICF/MRs) were decertified; (3) the decertification of five of six state institutions during 1989-1991; (4) the difficulty many private residential providers were having in retaining staff given levels of reimbursement; (5) the immediate need to respond to several community Intermediate Care Facilities for the Mentally Retarded (ICF/MRs) who decided to close; and (6) the changes in federal regulations from the Omnibus Budget Reconciliation Act of 1987 (OBRA) which gave people with developmental disabilities a choice to move from nursing homes. These factors and related legislative budget provisions had a tremendous impact on how the department managed the movement of over 700 people with developmental disabilities who moved or were diverted from state institutions, community ICF/MRs, and nursing homes during the 1989-91 biennium.

A more detailed explanation of some of the issues raised in the report is attached. Thank you for the opportunity to respond. Staff from the Division of Developmental Disabilities are available to respond to questions from you, your staff or members of your committee.

Sincerely,



PAUL TRAUSE  
Secretary

Attachment

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# **SUPPORTING DATA**

## **Appendix 3**

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The tables on the following pages include:

1. State institution and SOLA costs, FY1992.
2. States with highest costs per day at state institutions.
3. States with highest staffing ratios at state institutions.
4. State operated community placements: Washington and other states.
5. Typical costs in contracted placements for recent movers in Washington and other states.

### Residential Habilitation Centers (RHC) Costs, FY92

This chart includes expenditures charged to the RHC budget units in the state accounting system. Excludes external medical services, transfer payments, some capital costs, and DSHS overhead.

RHC	Expenditures	Resident Days	Cost per Resident Day	Annual Cost	Staff FTE	Average Residents	Staff per Resident
Fircrest	48,405,209	154,086	314.14	114,977	1,127	421	2.68
Rainier	47,063,078	176,778	266.23	97,439	1,068	483	2.21
Lakeland	31,821,730	113,826	279.56	102,321	733	311	2.36
Interlake	15,871,358	50,142	316.53	115,849	377	137	2.75
Yakima	14,465,532	47,214	306.38	112,136	320	129	2.48
F.H. Morgan	5,693,561	19,764	288.08	105,436	120	54	2.23
<b>TOTAL</b>	<b>163,320,467</b>	<b>561,810</b>	<b>290.70</b>	<b>106,398</b>	<b>3,746</b>	<b>1,535</b>	<b>2.44</b>

Source: Expenditures and staff FTE data from DSHS Budget Office, data as of 9/30/92.

Resident days were calculated by LBC staff, based on census data from DDD.

### State Operated Living Alternatives (SOLA) Costs, FY92

This chart includes expenditures charged to the SOLA budget unit in the state accounting system. Excludes expenditures for therapy, client allowances, medical and dental services, day programs, transfer payments, DSHS overhead, and field services.

Region	Expenditures	Resident Days	Cost per Resident Day	Annual Cost	Staff FTE	Average Residents	Staff per Resident
1 (Spokane)	1,744,492	4,672	373.39	136,662	47.21	12.77	3.70
2 (Yakima)	1,479,715	4,355	339.77	124,357	39.86	11.90	3.35
4 (Seattle)	3,420,455	12,246	279.31	102,228	90.37	33.46	2.70
5 (Tacoma)	1,164,204	3,294	353.43	129,356	31.11	9.00	3.46
<b>TOTAL</b>	<b>7,808,866</b>	<b>24,567</b>	<b>317.86</b>	<b>116,337</b>	<b>208.55</b>	<b>67.12</b>	<b>3.11</b>

Source: Expenditures and staff FTE data from DSHS Budget Office, data as of 9/30/92.

Resident days were calculated by LBC staff, based on information from program managers.

Table 2

### States with Highest Costs per Day, 1992-93, at DD State Institutions

This table shows the states that estimate FY93 state institutional costs at more than \$300 per resident day. The data are budgeted figures, as reported to the National Association of State MR Program Directors.

National Rank	State	Institution Cost per Resident Day	Residents on July 1, 1992
1	Hawaii	\$479	112
2	New York	\$446	6228
3	Vermont	\$435	98
4	Connecticut	\$393	1420
5	Oregon	\$390	535
6	Rhode Island *	\$379	145
7	Michigan	\$374	617
8	Idaho	\$351	161
9	North Dakota	\$339	195
10	Alaska	\$330	51
11	Massachusetts	\$321	2632
12	Oklahoma	\$318	803
13	Washington **	\$312	1498
14	Maine	\$302	237
15	Nevada	\$301	160
National Average		\$227	

#### Notes:

- \* The Rhode Island cost excludes 25 percent provider tax.
- \*\* The Washington cost excludes 15 percent IMR tax.

Source: Gary Smith, Nat Assn of State MR Program Directors, unpublished data as tabulated on November 5, 1992. The respondents were 48 state DD agencies.

Table 3

### States with Highest Staffing Ratios at DD State Institutions

This table shows the 12 states with the highest staff to client ratios at DD state institutions as of July 1, 1992. The data include all institutional employees, not just direct care staff. The data were collected in a recent survey by the National Association of State MR Program Directors.

National Rank	State	Institution Residents	Institution Staff	Staff per Resident
1	North Dakota	195	739	3.79
2	Oregon	535	2012	3.76
3	Vermont	98	346	3.53
4	Idaho	161	522	3.24
5	Hawaii	112	358	3.20
6	Oklahoma	803	2441	3.04
7	Massachusetts	2632	7949	3.02
8	Maine	237	702	2.96
9	Wyoming	242	711	2.94
10	Montana	161	457	2.84
11	Kansas	912	2289	2.51
12	Washington	1498	3700	2.47
National Average				2.05

Source: Gary Smith, Nat Assn of State MR Program Directors, unpublished data as tabulated on October 20, 1992. The respondents were 48 state DD agencies.

Table 4

### State Operated DD Community Placements: Washington and Other States

This table lists the ten states that use state employees as attendant care staff to support people with developmental disabilities in community-based settings, such as the State Operated Living Alternatives (SOLA) in Washington.\*

State	Description of State Ops	Residents	Persons per Living Unit	Cost per Resident Day
Washington	About 25 apts. or houses with full time shift staff	78	mostly 3	\$369 (all costs)
Arizona	14 group homes	78	6	No data
Connecticut	About 50 group homes for higher functioning people	450?	4 to 20	\$296 (all costs)
Massachusetts	About 28 8-bed ICF group homes, 30 8-bed duplexes, and 24 4-bed homes.	500 +	4 or 8	\$466 plus lease payments
Minnesota **	15 ICF group homes.	30 now, soon 90	6	\$241 (residential only)
Mississippi	26 group homes. Also clustered apartments with nearby live-in staff for high functioning clients.	180 in GH, 100 in apartments	GH = 6 to 10. Apts = 2 per apt. in 4-unit clusters.	Apartments = \$21 (residential only). No data on group homes.
New Jersey	19 group homes	133 (est.)	6 to 8	\$165 (res. only)
New York **	Mostly larger group homes. Some 4 to 6 person houses. A few apartments.	5,700	4 to 15	No cost data. Must be lower than Wash. (ratio=1.8 to 1)
Oregon **	7 group homes (some for medical or behavioral cases)	35	5	\$360 (operating plus other costs)
Rhode Island **	Mostly group homes, plus clustered apartments.	150?	mostly 6	\$187 (residential only)

\* In addition, DD state institutions have off-campus group homes in at least five states (Colorado, Louisiana, Missouri, Nevada, and Texas). Such programs are not really comparable with SOLA because the administrative structures and support services are institution-based.

\*\* Facilities are state-owned.

Source: Telephone contacts with state agencies, Oct-Nov. 1992, and other sources.

# Typical Costs in Contracted Placements for Recent Movers from State Institutions in Washington and Other States

State	Placement and Description	Size of Living Unit	Costs per Resident Day			Total	Difference from Washington
			Residential (a)	Day Program			
Washington	Average of "Movers to ITS" sample (b)	2 or 3	187	18		205 (b)	
Colorado	"Deinstitutionalized specialized" rate (c)	2	113	25		138	-67
Kansas	Supported living apartments	2	101	45		146	-59
Kentucky	Few movers	..	..	..		..	..
Maryland	"Alternative Living Units"	2 or 3	Can't break out movers. Lower rates than Washington (d)				
Michigan	Level IV-A rates (e)	6	114	25		139	-66
Minnesota	Adult foster care, enhanced waiver fund	3	145	37		182	-23
Missouri	Supported living apartments	3	No details. Rough estimate			150	-55
New Hampshire	Maximum level personal care (f)	3 or 4	136	35		171	-34
North Carolina	Maximum level ICF/MR, less room & bd.	5 or 6	169	..		169	-36
North Dakota	ICF/MR average, less room & bd.	7	125	32		157	-48
Ohio	Various	8 +	No details available--costs "same as institutions"				
Oregon	5 person group homes	5	126	33		159	-46
Rhode Island	6 person group homes	4 or 6	77	77		185	-20
Texas	GH or supported living "HCS + PPP"	3	117	25		142	-63

Table 5

## Notes

- Excludes room and board (not funded under HCB waiver), Medical Assistance, and transfer payments. Includes therapy, transportation, and various other services when known, or imputed at Washington level when not known.
- In the Washington movers to ITS sample, the rates (residential plus day program) ranged from \$51 to \$285 per resident day. If we exclude nine severely disabled movers from Interlake School with the highest rates, the average is \$188 per day.
- Colorado "D1 specialized" is the second highest rate level. The highest rate level is "D1 high needs," which totals \$196 per day and applies to 45 to 50 people statewide.
- Maryland ALU average (2,200 clients) is \$85 per day (residential only) for 4 to 5 staff hours. Washington ITS (1,000 clients) as of March 92 = \$117 (9 hours). Washington ITS + TS combined = \$98 (7.2 hours).
- Michigan level IV-A is the second highest rate level. Highest is level IV-B, which totals \$160 per resident day.
- New Hampshire "maximum level" rate is the second highest. A higher rate of \$181 a day (residential only) applies to 57 people statewide with intense medical and behavioral needs.

Source: Discussions with state agency staff, Sept. Nov. 1992.



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# **POLICY RESEARCH BRIEF**

## **Appendix 4**

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# Policy Research Brief

*A summary of research on policy issues affecting persons with developmental disabilities.*

March 1989

Vol. 1, No. 1 (rev.)

## Deinstitutionalization of Persons with Mental Retardation: The Impact on Daily Living Skills

Nationally, the policy of deinstitutionalization of persons with mental retardation has been pursued for 20 years. In fiscal year 1967, state institutions for persons with mental retardation had an average daily population of 194,650; by fiscal year 1987, the average daily populations of the same institutions had decreased by 100,000 persons to 94,696 (White, Lakin, Hill, Wright & Bruininks, 1988). Much of the early momentum for deinstitutionalization was drawn from recurring evidence of very poor, often deplorable, conditions in state institutions, including unsafe and unsanitary conditions, overcrowding, regimentation, and progressive debilitation of residents. Since then, much has been done to improve these conditions. Perhaps the most important effort toward improvement was the enactment of the Intermediate Care Facility for the Mentally Retarded (ICF-MR) program in 1971, which established specific standards for institutional care in return for federal participation in at least half the costs of care. Today the ICF-MR program certifies 93% of all state institution "beds" (Lakin, Hill, White & Wright, in press). Court cases in the majority of states also have required significant improvements in the conditions of one or more state institutions. Related to the above, as well as to the general commitment on the part of states to improve institutional care, per resident expenditures in 1987 (\$54,500) were five times greater in real dollars than per resident expenditures in 1967 (White et al., 1988).

In response to policy deliberations at the federal and state levels that would continue the depopulation of state institutions, including in many instances closure of entire institutions, advocates of maintaining institutional services are suggesting that today's institutional care may be as effective or more effective than community-based care. This review of literature responds to that issue with respect to a single, but important, area: the changes in adaptive behavior (the basic skills of daily living) of individuals moving from state institutions to community living arrangements. It does so by reviewing all published and unpublished literature meeting standards for quality and identifiability.

### Research Selection

Research screened for inclusion in this summary was identified from the following sources: 1) a computer search of the Psychological Abstracts from 1976 to 1988; 2) a computer search of the ERIC research data base from 1976 to 1988; 3) manual review of major journals in mental retardation from 1980 to 1988; 4) review of Dissertation Abstracts from 1980 to 1988; and 5) requests to all state mental retardation agencies for studies of behavioral change for persons living in different kinds of residential facilities. Over 50 studies were identified and screened according to the following criteria for inclusion in this review: 1) followed 6 or more individuals from public institution placements through at least 6 months of living in a community facility, with community facility defined as having 15 or fewer residents and located off the grounds of a large facility; 2) collected baseline data while persons were still in the institutions; 3) measured overall adaptive behavior and/or specific types of adaptive behavior (e.g., self-care/domestic skills, communication skills, social skills) in the same manner and with the same instruments in both settings; 4) reported basic demographic and diagnostic information on institution and community facility subjects; and 5) discharged community-based facility subjects from institutions in or after 1975. The 18 studies meeting these criteria were included in this review of adaptive behavior outcomes. In addition, where any of the studies of changes in adaptive behavior also examined changes in problem behavior, those results were also summarized.

### Results

Tables 1 and 2 (see pages 3-4) show the changes in three categories of behavior of individuals with mental retardation as they moved from large state institutions to small community living arrangements. The first category was change in overall adaptive behavior score. The second category was change in one or more of seven specific types

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of adaptive behavior. These results were summarized according to the types that most closely matched the categories reported in each study. The third category was change in problem behavior associated with a move to a community living arrangement.

Outcomes were reported in terms of the direction of change with the public institution as the point of reference. That is, a positive outcome (+) means adaptive behavior was greater in the community, or that problem behavior was less evident. A negative outcome (-) means the adaptive behavior was lower in the community, or that problem behavior was more evident. Two pluses (++) or minuses (--) are used when the magnitude of difference indicates a probability of less than 5% that the result occurred because of random error (statistically significant). One plus (+) or minus (-) indicates that a difference was found between the groups, but that there was more than a 5% chance that the result was due to random error, or that the differences were not tested for statistical significance. A zero (o) indicates that no difference was found or that statistically insignificant findings were reported in a manner not permitting evaluation of the general tendency. Blanks indicate the topic was not studied or that no data were reported.

Table 1 shows the outcomes reported for studies that used an experimental/contrast group format. Those studies compared the changes in adaptive behavior (and in some instances, problem behavior) for persons who moved to the community with changes for persons of similar characteristics who remained in state institutions. Some of the studies involved random selection of subjects for either the experimental (community living) or the contrast (continued institutionalization) group. Other studies matched individuals who moved and individuals who stayed on characteristics such as sex, age, measured intellectual level, and initial level of adaptive behavior. The adaptive and problem behaviors of each group were measured both before and after the move. Table 1 summarizes the differences between groups in changes in adaptive and problem behavior after the experimental group moved to community settings.

Table 2 shows the outcomes reported in studies utilizing a longitudinal approach to measuring changes in adaptive behavior (and, in some instances problem behavior). These studies measured behavior before or at the time of deinstitutionalization and then at various times after the move. Some studies measured change once after the move while others measured change repeatedly. The results summarized on Table 2 reflect overall changes in adaptive behavior after movement to community settings.

## Discussion

All eight experimental/contrast group studies reported statistically significant greater achievement in either overall adaptive behavior or in the basic self-care/domestic skill domain for those who moved to community living

arrangements relative to those who remained in state institutions. There were statistically significant changes favoring community over institutional settings in numerous other adaptive behavior areas as well. None of the experimental/contrast group studies, however, reported statistically significant differences between groups for changes in problem behaviors.

Among the longitudinal studies, 5 of the 10 reported statistically significant increases in overall adaptive behavior or in the basic self-care/domestic skill area after movement to the community. A sixth study would have most probably shown statistically significant changes, but no statistical tests were employed and the reported data did not permit such testing at this point. Three other studies in this area showed positive behavior changes after movement to a community residence, but the magnitude of the changes was not statistically significant. A number of statistically significant improvements were noted in specific types of adaptive behavior. There was considerable variation in the reported changes in problem behavior in this set of studies.

Overall, 13 of the 18 studies summarized for this report noted statistically significant improvements in either overall adaptive behavior or in the basic self-care/domestic skill area. Seventeen of 18 studies showed at least a tendency toward improved adaptive behavior associated with movement to the community. Conversely, in only one was any negative change in any area of adaptive behavior associated with community placement. In that study (Kleinburg & Galligan, 1983) a small (statistically insignificant) decrease was noted in the domains "vocational behavior" and "recreation/leisure". Therefore, one must conclude that available research provides considerable support for the assertion that people who move from state institutions to small community living arrangements can be expected to experience increases in adaptive behavior skills. On the other hand, for the ten studies that reported changes in problem behavior, no consistent pattern of change was demonstrated related to movement from institutional to community settings. While again it is noted that this summary only examined changes in problem behavior that were included in studies focusing on adaptive behavior, these studies do not support the assertion that people who move from state institutions to small community living arrangements can be expected to experience reductions in problem behaviors solely as a function of moving.

**Table 1**  
**Experimental/Contrast Group Studies**  
**Behavioral Outcomes Associated with Movement from State Institutions to**  
**Small (15 or fewer persons) Community Living Arrangements**

Author (date)	State	# Subjects		Age	Time (months)	Level of MR				BEHAVIORAL OUTCOMES		
		Exp.	Cont.			Bord/ Mild	Mod	Sev	Prof	Adaptive Behavior General/ Overall	Specific Domains	Problem Behavior
Bradley et al. (1986)	NH	80	80	AC	72	X	X	X	X	++	o,d	-
Close (1977)	OR	6	6	A	12			X	X		++ a	
Conroy et al. (1982)	PA	70	70	A	24	X	X	X	X	++		+ <sup>1</sup>
D'Amico et al. (1978)	WV	6	7	AC	6,12 <sup>2</sup>	X	X	X	X	++ <sup>3</sup> ++ <sup>4</sup>	++ a,b,c,f o d,e	
Eastwood et al. (1988)	N.E. USA	49	49	A	60	X	X	X	X		++ a,c,d,e,f,g + b	
Horner et al. (1988)	OR	22	23	AC	60	X	X	X	X		++ a,c,f	+
Rosen (1985)	AR	58	58	A	24	X	X	X	X	++	++ a,d,e,f	
Schroeder et al. (1978)	NC	19	19	A	12			X		++	+ a,b,c	

<sup>1</sup>The movers stayed the same while the contrast group got worse.

<sup>2</sup>After measuring behavior at 6 months, 2 of the control subjects were randomly assigned to move to the community.

<sup>3</sup>Time 1 (4 exp., 9 cont.)

<sup>4</sup>Time 2 (6 exp., 7 cont.)

#### Outcomes

- ++ = statistically significant improvement relative to the contrast group
- + = improvement relative to the contrast group but not statistically significant
- o = no change relative to the contrast group
- = decline relative to the contrast group but not statistically significant
- = statistically significant decline relative to the contrast group

#### Adaptive Behavior Domains

- a = self-care, domestic
- b = communication/language
- c = social skills
- d = vocational
- e = academic
- f = community living
- g = recreation/leisure

#### Age

- A = adult
- C = children
- AC = adults and children

**Table 2**  
**Longitudinal Studies**  
**Behavioral Outcomes Associated with Movement from State Institutions to**  
**Small (15 or fewer persons) Community Living Arrangements**

Author (date)	State	# Subjects	Age	Time (months)	Level of MR				BEHAVIORAL OUTCOMES		
					Bord/ Mild	Mod	Sev	Prof	Adaptive Behavior General/ Overall	Specific Domains	Problem Behavior
Bradley et al. (1986)	NH	93	AC	84	X	X	X	X	++	++ d	-
Colorado Div. of DD (1982)	CO	108	AC	12	X	X	X	X	+		
Conroy et al. (1985)	PA	383 <sup>1</sup>	AC	72 <sup>1</sup>	X	X	X	X	++		+
Conroy et al. (1988)	CT	207	A	24	X	X	X	X	++	++ d	--
Feinstein et al. (1986)	LA	158	AC	9	X	X	X	X	++		++
Horner et al. (1988)	OR	23	AC	60	X	X	X	X		++ a,c,f	+
Kleinburg et al. (1983)	NY	20	A	12		X	X	X		+ a <sup>2</sup> ,b,c - d,g	+ <sup>3</sup> - <sup>4</sup>
O'Neil et al. (1985)	NY	27	A	9	X	X	X	X		o a,b <sup>5</sup>	
Thompson et al. (1980)	MN	5	A	24			X	X	+ <sup>6</sup>	+ a,b,c,f,g <sup>6</sup>	
State of WI (1986)	WI	24	A	18	X	X	X	X		++ b,c,d,f + a,e	o

<sup>1</sup>This study included 6 groups, all of which showed significant gains, the largest group measured over the longest time is reported here

<sup>2</sup>Domestic activities increased significantly, but domestic behavior showed no overall change

<sup>3</sup>IQ above 20

<sup>4</sup>IQ below 20

<sup>5</sup>Significant increases were found in 4 of 16 subcategories in these skill areas

<sup>6</sup>Mean differences were not tested for statistical significance

#### Outcomes

++ = statistically significant improvement after move to the community

+ = improvement after move but not statistically significant

o = no change after move

- = decline after move but not statistically significant

-- = statistically significant decline after the move to the community

#### Adaptive Behavior Domains

a = self-care, domestic

b = communication/language

c = social skills

d = vocational

e = academic

f = community living

g = recreation/leisure

#### Age

A = adult

C = children

AC = adults and children

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